Wilson (H. P. C.)

CIRCUMSCRIBED PERITONEAL DROPSY SIMULATING OVARIAN DROPSY.

BY H. P. C. WILSON, M.D.

Surgeon to the Hospital for the Women of Maryland; Fellow of the American Gynæcological Society, and British Gynæcological Society; Member of the British Medical Association; Vice-President of the Baltimore Gynæcological and Obstetrical Society, etc., etc.

Read before the Academy of Medicine, March 2nd, 1886.

Reprint from the Maryland Medical Journal, of Feb. 20th, 1886.

BALTIMORE:
JOURNAL PUBLISHING CO., PRINT,
35 PARK AVENUE,
1886.

CIRCUMSCRIBED PERITONEAL DROPSY SIMULATING OVARIAN DROPSY.

BY H. P. C. WILSON, M.D.

Surgeon to the Hospital for the Women of Maryland; Fellow of the American Gynæcological Society, and British Gynæcological Society; Member of the British Medical Association; Vice-President of the Baltimore Gynæcological and Obstetrical Society, etc., etc.

Read before the Academy of Medicine, March 2nd, 1886.

Reprint from the Maryland Medical Journal, of Feb. 20th, 1886.

BALTIMORE:
JOURNAL PUBLISHING CO., PRINT,
35 PARK AVENUE,
1886.

CIRCUMSCRIBED PERITONEAL DROPSY SIMULATING OVARIAN DROPSY.

BY H. P. C. WILSON, M.D.

Surgeon to the Hospital for the Women of Maryland; Fellow of the American Gynæcological Society, and British Gynæcological Society. Member of the British Medical Association; Vice-President of the Baltimore Gynæcological and Obstetrical Society, etc., etc.

Mr. President and Gentlemen of the Academy of Medicine: I desire to call your attention this evening to a case of circumscribed abdominal dropsy, limited by peritoneal adhesions so complete, as to accurately simulate ovarian dropsy. It could not be called cystic dropsy, because the fluid was not contained in a distinct sac; but by adhesions from general peritonitis, the fluid was restricted to the front and lower part of the abdomen, and not allowed to gravitate throughout its whole extent. Change of the patient's position did not change the position of the fluid, and there was nothing in her history or symptoms to cause us to suspect a former, or recent, peritonitis. She had never been sick a day in her life, and all her organs were acting well.

Mrs. Jas. P., married, æt. 38. The mother of seven children—twins once, four miscarriages—four times delivered with forceps. Began to menstruate at 14. Noticed a swelling in the abdomen 1st of September 1885. Could not locate its beginning in either groin or lower abdomen. Has had regular menstruation always, except when pregnant.

She was sent to me by Dr. N. B. Baker, one of the most eminent physicians in Martinsburg, W. Va., with the statement that she had an ovarian tumor. I confirmed his diagnosis, when she was admitted to the Union Protestant Infirmary, February 12th, 1886.

She had a prominent fluctuating tumor of the lower abdomen. Dull on percussion to two inches above the umbilicus, dull in either groin, and presenting the characteristic, round and prominence of a cystic tumor of the ovary. Percussion was clear in both lumbar regions. Changing the patient's position did not change the lines of dulness anywhere. There was no tenderness over the abdomen to any amount of thumping or pressure.

The uterus was free in the pelvic cavity, and measured three inches by the sound. She had the facies ovariana. I had no doubt that the case before me was one of cystic disease of the ovary.

February 15th, at 2 P. M., was appointed for the operation; sponges, instruments, rubber cloths and dressings had been thoroughly carbolized. The carbolic spray had been going on in the operating room for one and a half hours, but was stopped before the operation began. Dr. N. B. Baker (whose patient she was) and Drs. Keyser, Faucett and Robert T. Wilson were present, with the two hospital nurses. The patient was given 3 i of whiskey, and chloroformed by Dr. Keyser. I again reviewed my former examination, and was satisfied that I had a simple cyst of the ovary, without complications, to deal with.

Not feeling well, nor in an operating humor, I handed the instruments to my son, Dr. Robert T. Wilson, and told him to proceed with the operation. He cut carefully into the abdominal cavity, making an incision of three inches, down to the peritoneum, and entering the cavity by an opening of about half an inch. Immediately, there was a gush of a greenish yellow fluid, and turning the patient on her side, about one and a half gallons escaped; enlarging this opening to three inches and looking in, a solid tumor was discovered about nine inches long, six inches broad and three inches thick. The walls of the abdominal cavity were festooned with recent lymph, and patches of the same were

seen every where. The hand passed in, found adhesions every where. The uterus and ovaries were normal, but we could not determine by the touch and sight what this tumor was, till we had lifted it from the abdominal cavity, and found it was made up of coils of intestine agglutinated with lymph. It was so firm and solid, that at first sight, it was hard to believe it a mass of intestines. It was not agglutinated to other abdominal viscera, but seemed to be free in the peritoneal fluid.

Dr. Robert Wilson returned the mass to the abdominal cavity, and closed the abdominal opening with seven silver wires, and dressed the wound as usual in ovariotomy.

Thus the case which I was sure was ovarian dropsy, turned out to be localized peritoneal dropsy, the result of peritonitis.

This woman told me before the operation, and has several times comfirmed her statement since, that she had never been sick a day in her life, except during confinements, and her youngest child is now two years old. Dr. Baker, who has been her physician ever since her marriage, assured me that her statement was correct.

For my diagnosis I had before me a fluctuating tumor, occupying the lower part of the abdominal cavity, and the

abdomen was rounded prominently about the umbilicus. In the dorsal position, it did not bulge out to either side. There was clearness on percussion in both lumbar regions. Changing the position of the patient did not change the lines of dulness on percussion. She had no tenderness on abdominal pressure. All of her organs were acting well, and the pelvic viscera were as they should be in such a supposed ovarian cyst. No anasarca; no œdema of lower extremities.

I do not see how we were to avoid falling into the error into which we were lead. Had we tapped her (which should never be done in ovarian tumors if possible) we would have been none the wiser, but would rather have had our diagnosis confirmed by the solid tumor which would have remained. I have not implicit confidence in the ovarian cell as a means of diagnosis.

Dr. Peaslee says, in his book on ovarian tumors: "It might be expected that the removal of all the fluid from the peritoneal cavity would at once decide between ascites and an ovarian cyst. But Dr. McDowell and Dr. A. G. Smith had a patient, who had tapped herself with a trocar and canula, 90 times; in whom, on opening the abdominal cavity to remove an ovarian cyst, they found only a

mass of intestines matted together by adhesions."

Dr. T. Spencer Wells, in his work on ovarian and uterine tumors, says: "The fluid poured out as the result of inflammation of the peritoneum, instead of lying free in the cavity, is sometimes confined in pouches formed by adhesions among the viscera, or by false membrane deposited during the disease, or by attachments of the omentum or mesentery." "The fluctuation, even if distinct, is always limited in extent and confined to the same spots. The intestines are found behind or beside the tumor, and do not as in ascites rise up to the front of the abdomen, or vary with the position of the patient."

Dr. West, in his work on diseases of women, says: "One instance of this latter occurrence has come under my own observation, in which between four and five quarts, of a *dark* fluid, were collected between folds of the omentum, and during the patient's lifetime, frequent discharges of a similar fluid had taken place from the umbilicus. The dropsy had during the life of the patient been supposed to be ovarian; but though malignant disease of both ovaries was discovered, yet neither of them contained fluid at all similar in character to that which was found in the omentum; nor, indeed, could either be detected till after

the fluid in the omental cyst had been let out. I am aware of no means by which such cases are to be discriminated from ovarian dropsy. As far as I know, their nature has scarcely ever been suspected during the lifetime of the patient."

Dr. T. Spencer Wells reports a case in which he suspected ovarian dropsy. He carefully opened the abdominal cavity below the umbilicus. No cyst appeared. A large quantity of opalescent fluid escaped. The whole peritoneum was studded with tubercles. Some coils of small intestines were floating, but the great mass was bound down with the colon and omentum, towards the back and upper part of the abdomen. She went through a sharp attack of peritonitis, but recovered, and has been well ever since the operation. No more fluid was secreted, and the patient regained health and strength, and married. The operation was done in 1862, and Mr. Wells reports the woman well in 1881.

I might report many other cases of circumscribed peritoneal dropsy, so simulating ovarian dropsy, as to lead to an erroneous diagnosis which was only rectified by an exploratory incision, or a post-mortem examination, but I will not weary you further.

The greater my experience, the more I am impressed with the propriety of

such incisions, in all cases of abdominal tumors, where life is involved. I am convinced that many more lives are lost for the want of such incisions, than on account of them.

To Dr. Robert T. Wilson I am indebted for the following history, as well as the treatment of the case subsequent to the operation.

First day, 15th February, 9 P. M.—Temperature 103, pulse 120, respiration 22. Abdomen distended. All dressings were removed, and the abdomen covered with cloths, wrung out of cold water, to be renewed every few minutes throughout the night. Pulse feeble. Gave 10 drops of tincture digitalis every two hours and a teaspoonful of very hot water occasionally. At 9.35 P. M. she was given 20 minims of muriate of quinia and urea, hypodermically, and ordered half an ounce of milk every two hours. At 10 P. M. she was becoming restless, and was given 10 m. of Magendie's solution of morphia under the skin.

Second day, 16th February 7.30 A. M.—Temperature 101⅘, pulse 100, respiration 20. Had a good night. Took nourishment well. Passed urine and also flatus freely. Had no nausea or pain. Tongue dry. Gave hypodermically 7 m. of Magendie's solution. Digitalis, cold applications to abdomen, and milk continued. A teaspoonful of whis-

key was added to each portion of milk.

1 P. M.—Temperature 100¾, pulse 92, respiration 20. Tympanites great, but continues to pass flatus freely. Urinates freely. Bears her milk, whiskey and digitalis well. Treatment continued as before.

4.30 P. M.—Temp. 101½, Pulse 104, respiration 24. Pulse stronger. Tympanites increased. No unusual tenderness after such an incision. No pain. Is calm and comfortable. At 3.45 vomited for the first time. She attributed it to the whiskey, which was always disgusting to her. So it was stopped by the mouth and ʒ ij. were given per rectum every six hours. ʒ j. of milk and ʒ ij. of lime water were given by the mouth every two hours. Cold water dressings and digitalis continued as before. Tongue still dry.

Third day, 17th February, 8 A. M.—Temperature 98, pulse 100, respiration 20. Pulse stronger. She passed a comfortable night. Had no nausea nor vomiting. No pain. Passed urine and flatus. Took nourishment well. All treatment continued as yesterday.

3.45 P. M.—Temperature 98½, pulse 112, respiration 20. Has had two liquid evacuations, passing urine and much flatus at the same time. Stopped whiskey enemas, and gave 25 drops of laudanum in an ounce of starch water, ordering the same to be repeated after

each evacuation ; she required no more. This enema, and the two small hypodermics of morphia, reported above, is all the opium given in this case. 3 ij. of sherry wine, every three hours, by the mouth, were ordered, as she thought she would relish it; but it was soon discontinued as it became distasteful. Tympanites still great. Milk and lime water, digitalis and cold water dressings continued. Tongue more moist.

Fourth day, 18th February, 9.30 A. M.—Sleeping. Pulse 100, respiration 18. Had a good night, and bore her nourishment and medication well.

5 P. M.—Temp. 99, pulse 100, respiration 20. Has passed much flatus. Abdomen soft and bears pressure well. Abdominal wound united by first intention. She expresses herself as very comfortable. Treatment continued.

Fifth day, 19th February.—Temp. 98½, pulse 100, respiration 20. Doing well. Tongue moist. Abdomen soft. Taking 3 ij. of milk every two hours, with lime-water. Treatment continued.

Sixth day, 20th February.—Temp. 98½, pulse 100, respiration 20. Doing well, and treatment continued.

Eighth day, 22nd February.—Temp. 100½, pulse 100, respiration 20. A small abscess opened along one of the wires which no doubt sent up her temperature. Abdomen soft and no tenderness. Tongue

moist. Appetite ravenous. Wants "middling and greens." She is now allowed all the milk she wants. A soft boiled egg for breakfast, and good soup for dinner. She had some sweating last night, and was ordered ʒj. of infusion of cinchona bark, with 25 drops of aromatic sulphuric acid in it, three times daily. She is bright and cheerful and jokey, and expresses herself as feeling very well. The digitalis was stopped.

Sixteenth day, March 2nd.—The patient has had no unpleasant symptoms since last report, except the formation of several abscesses along the wires. They united and caused a superficial gaping of the abdominal incision. This is rapidly closing by granulation. She looks much improved since the operation. Appetite good; sleeps well; bowels regular; is cheerful and bright, and out of all danger.