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INTRALIGAMENTOUS TUBAL PREGNANCY; SUCCESSFUL REMOVAL BY ABDOMINAL SECTION OF A FOUR-POUND LIVING CHILD WITH ALL ITS APPENDAGES; MOTHER AND CHILD STILL LIVING AND IN GOOD HEALTH, JANUARY 15, 1889.

BY

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MRS. C., age 39, bore one child nineteen years ago. Suffered from frequent paroxysms of intense pain and rapidly increasing abdominal enlargement, since her flow stopped last Christmas.

She was admitted to my private hospital on July 9th; operation July 10th.

Abdominal inspection and palpation showed tumor extending from near pubes upwards, and to the right reaching near liver. Conjoined manipulation disclosed uterus normal in size, well up between tumor and symphysis pubis. There was not less than three inches of fat between integument and tumor. I failed to detect sound of fetal heart. Breasts not enlarged. Very little discoloration around the nipple.

Abdominal section revealed extra-uterine pregnancy, tubal variety.

The tube seemed to have much of the right broad ligament surrounding its uterine attachment, as if the tube had been originally beneath the peritoneal fold of the broad ligament.

The sack containing the child was a dark purple and tore open easily on the touch of small forceps.

Placenta was nearly under line of abdominal incision, yet I was enabled to open sac and extract child without detaching much of its tissue.

Any manipulation of the sac caused hemorrhage. I determined at once to remove tube and placenta in mass, and began by separating an adherent intestine and then an adherent omentum, being compelled to use pressure forceps and ligate five times before I reached and surrounded the tube with my fingers.

By this time there was free hemorrhage from the margins of placenta and tube.

I applied Eastman's clamp below my fingers around the neck of the sac, and found by this means I could so constrict as to arrest all bleeding; then cut off above clamp, and using No. 14 iron-dyed silk, quilted the pedicle (which the c amp had made for me) with cobler's stitch.

I washed out the peritoneal cavity with pure water (temperature 105°) three times, put in glass drainage tube, and closed wound with silk-worm gut, and found to my great satisfaction that the patient had suffered little shock. Her highest temperature was 102°.

Bowels moved on third day, and drainage tube was removed on fifth day. She is now surely convalescent, with normal pulse and temperature.

The child is well and growing as nicely as any infant I have seen. I am under lasting obligations to Dr. A. W. Pattison and my faithful nurses, the Misses Prough (sisters), for their efficient assistance in the operation; also

to Dr. J. F. Barnhill, for his skillful administration of ether. There were no others present at the operation, as "in a multitude of counsel, there is safety to the counsellors, but not to the counseled." Drs. Todd, Waterman and Elder, of this city, in addition to those present at operation, examined the tube and child, all concurring in the belief that the child was eight months, and that the tube had not ruptured.

The only similar case which I have been able to find is the following, from the *Am. Jour. of Med. Sciences*, Feb., 1888.[1] The two cases referred to by J. Grieg Smith (second edition "Abdominal Surgery") are *not* parallel. In Jessup's case, no tube was removed, and in Martin's case, while the tube was removed, the child was moribund.

[1]The mother and child are, at this date, August 14th, in good health.

"At a recent meeting of the Society of Physicians of Vienna, Breisky reported the case of a woman, aged 30 years, who had given birth to a living child six years previous to her extra-uterine conception. She suffered from peritonitis after confinement, and never had been free from pelvic pains. Extra-uterine conception was followed by chronic peritonitis; fetal movements were perceived at five months, when the pains lessened. Breisky diagnosed intra-ligamentous, tubal pregnancy. On examination by palpation, the uterus could be felt, lying in front of the tumor. By vaginal examinaton, the true pelvis was found to be empty, the vagina drawn toward the left. The tumor was at the right of the uterus, the fetal parts could be outlined, and the heart-sounds heard.

"The operation was performed at the end of eight months of pregnancy. After a central incision, the fetal sac presented in the wound; it was stitched to the abdominal wall by four sutures; at its thinnest point, an opening was made, and the child was rapidly extracted. It weighed over five pounds, was asphyxiated, but was promptly resuscitated. The four flaxation sutures were then removed; the sac was drawn out, ligated at its junction with the uterus, and removed. Externally the adhesions were but partially broken up, as the sac was adherent to the intestines and omentum. The sac, placenta, and membranes were removed, and the wound drained and sutured. The mother recovered perfectly in three weeks.

"The sac presented a considerable development of muscular tissue, and seemed mostly developed from the serosa; the placenta was large, and showed adherent lobules.

"Three weeks after delivery, the child died from inflammation of the umbilical vein—a termination not to be ascribed to the operation.

"Breisky claims this is the first case of the successful removal of the living fetus, with all its appendages, in extra-uterine pregnancy. From the consideration of three cases previously operated upon by him, Breisky believes that in advanced cases of extra-uterine pregnancy, when the fetus lives, we should extirpate the entire sac. To await the formation of a lithopedion is not admissible, as perforation of the bladder or intestine, or septic infection may result.—*Wiener medizinische Presse*, No. 48, 1887."

REMARKS ON PELVIC PERITONITIS,

AND ON MY YEAR'S WORK IN ABDOMINAL SURGERY. (FORTY CASES.)

From my experience of the past year, I feel warranted in emphasizing the importance of inflammations of the pelvic peritoneum, a disease very frequently overlooked, and more common than any other disease of woman's pelvis. Pelvic cellulitis, according to the text-books, more frequently follows child-birth than pelvic peritonitis. Post-mortem examinations, and within the past few years abdominal sections, are making it more apparent that without some pre-existing peritonitis, the trauma of child-birth, and many other causes heretofore mentioned, would less frequently result in inflammation of the cellular tissues. Winckel found in thirty-three per cent. of of autopsies (for all diseases) well-marked inflammation of some portion of the pelvic peritoneum. Of five hundred and seventy-five post-mortem examinations, the same author found in one hundred and eighty-two cases well-marked disease of the Fallopian tubes. This is an instructive statement, and should lead to the early and efficient medical treatment of salpingitis, which so frequently extends to other structures in consequence of the movements and periodical engorgement of the tubes. Nearly all post-mortem examinations of the chest show inflammation and adhesions of some portion of the serous lining. This being true, how much more likely would we be to find the results of inflammation in the serous covering of the female pelvis, a structure vastly more complicated anatomically, and physiologically much more abused. With a pathology until within the past few years little understood, therapeutics are vague and unsatisfactory.

The sharp, stitch-like pains felt by young ladies before, during and after menstruation are, as in the chest, significant of more or less inflammatory adhesion of the serous covering of some portions of pelvic structure. The term pelvic peritonitis may be applied to a circumscribed spot, or signify "co-existence of perimetritis, perisalpingitis, peri-oöphoritis, pericystitis and periproctitis." (Winckel.)

The delicate silken membrane becomes opaque at first, and adheres to the same membrane nearest in contact; as the uterus, rectum, tubes, bladder, each recurring attack strengthening and extending the adhesions. Serum poured out undergoes chemical changes, forming abscesses in the broad ligaments, between coils of intestines, and by its progressive work of destruction materially impairing functions, sometimes causing complete intestinal obstruction, or again abscesses discharging into bowel, vagina, or through the external integument, seriously complicating ultimate cure.

Causation.—Congenital defects may so retard, modify or complicate menstruation as to cause inflammation of the serous covering of the undeveloped organ. The brain-cramming of our school system has much to answer for in retarding the development of the pelvic organs in young girls.

Mr. Tait speaks of the eruptive fevers interfering with the proper development of the epithelial lining of the tubes. My limited experience furnishes several cases where abdominal section proved the existence of well-marked

disease of the Fallopian tubes, the clinical history leading us unmistakably back to scarlatina which had so affected the epithelium of the kidney as to produce the well-known dropsical sequlæ of that disease. Recently demonstrated facts show that the Fallopian tubes undergo important changes at puberty; they become more highly vascular, there is increased development of their longitudinal fibers, and their mucous lining is covered with ciliated epithelium. Organs anatomically so complex as the Fallopian tubes surely have a susceptibility to disease far greater than has been heretofore believed.

Let us emphasize, then, the important causative relations borne by febrile disease to arrest of development of the pelvic organs in girls, organs imperfectly developed being vastly more susceptible to disease than those perfectly developed.

Saenger, of Leipsic, Noeggerath, of New York, and others, have emphasized the importance of gonorrheal virus as a cause of pelvic peritonitis. I must dissent from the *extreme* views of these men; at the same time I often shudder for the marriageable young ladies, when I remember what a large per cent. of marriageable young men have suffered from gonorrhea and have been imperfectly cured, or rather not cured at all. Few of them consult competent experts, but, on the contrary, get some "clap mixture" from a friend or druggist, ignorant of the fact that a skillful adaptation of a given remedy to the particular stage of the disease marks the measure of its success. In applying for a policy in life insurance, the applicant must honestly state all the diseases he has had. If a false statement is made, the policy may be forfeited. Oh, that parents could secure from young men truthful statements as to all the diseases they have had, when they ask the hands and hearts of their marriageable daughters!

The teaching heretofore extant that gonorrhea in the female is less serious than in the male is wrong, *and must be rewritten.* I agree with Van Buren and Keyes who say "gonorrhea sends more to the tomb than syphilis," and let me add my belief that the same foul virus sends twice as many women to the grave as men. While the female urethra is less likely to suffer, the Fallopian tubes and ovaries furnish a secret lurking-place for the gonococcus, where its work of destruction is beyond the reach of remedial agents, at a stage of the disease when total annihilation could be hoped for. Means used to prevent conception, especially cold-water injections used after coition, cause many cases of tubal and ovarian inflammation. Induced abortion also produces much disease and many deaths from peritonitis.

Treatment.—Opium is the remedy in the beginning. It should not be continued in chronic cases, for fear of "the opium habit." Hot applications over the lower part of the abdomen, combined with hot antiseptic vaginal douches, with a Hildebrandt douche, this instrument enabling us to use water ten or fifteen degrees hotter than can be borne by the external parts, while it carries off the water without the aid of the bed-pan. It was not my purpose, however, to speak of treatment, except in the advanced stage of the disease, and by surgical means.

In case where each recuring menstrual period rekindles the inflamma-

tion, Battey and Tait have suggested the removal of the uterine appendages to relieve the pelvis of its periodical congestion, by bringing on the menopause. This is undoubtedly a warrantable operation in some cases, when all other means have failed. Some argue that the operation is being done too often. My limited experience induces me to believe that, where the uterine appendages have been unnecessarily removed once, ten women have gone down to the grave whose lives could have been saved by timely removal of the appendages, if the same were done by skillful hands.

Let those who condemn salpingo-oöphorectomy carefully consider the following propositions, using anatomical, physiological, pathological, and therapeutical common sense in so doing. If the ovaries and Fallopian tubes could, like the male testical and epididymis, descend during early life, and remain within reach of poltices, iodine, suspensory bandages, etc., and if they were free from the regular monthly engorgement which all the pelvic organs are subject to, they, too, might be relieved of congenital defects, physiological abuses, the destructive sequelæ of mumps, the fevers of childhood, and the pernicious gonorrheal virus, before disorganization had so far advanced as to warrant their removal. When inflammation has gone on to suppuration, whether pus has been discharged by the rectum, vagina, or not, the treatment instituted by Mr. Tait is a valuable means of cure, namely, opening the abdomen, draining the abscess (whether in broad ligament or between coils of intestines) from its fountain source, stitching peritoneal margins of abscess to abdominal wound, and putting in a drainage tube. There are many such cases with pus discharging from the rectum, or cul-de-sacs of vagina, safely curable by this method of treatment. I must say, after some experience in this method of treatment, that I prefer it to either plunging in a bistoury or trocar high up, or dilating vagina or rectum, and dilating the sinus even if the same is in reach, which it frequently is not, for the important reason that the former treatment in expert hands is less dangerous. Martin's method of drainage through Douglas' pouch may be more suitable in some cases.

CASES.

CASE I.—*Pelvic abscess originating from pelvic peritonitis, communicating with rectum.* Over one quart of fetid pus removed from broad ligament at time of operation. Abscess sac stitched to wound. Glass drainage tube. Cure in seven weeks. Dr. A. W. Patterson was present at operation.

CASE II.—*Abscess had been discharging by rectum.* A pint of puss removed at operation. Abscess sac stitched to abdominal wound. Recovery perfect in five weeks. Dr. L. L. Todd present at operation.

CASE III.—*Chronic peritonitis following severe colic.* Abdominal cavity filled with inflammatory products, uniting the large and small intestines, in many places, into one common mass. Complete intestinal obstruction for six days. Separated adhesions of bowels, removing large quantities of pus from between coils of bowels. Drainage. Abscess sac stitched to abdominal wound. Recovery complete. Dr. J. F. Barnhill was present at operation.

CASE IV.—*Chronic salpingitis and ovaritis*, appendages firmly adherent to broad ligament. Disease of thirteen years' duration. Removed appendages, used drainage. Patient says she "feels better than for a dozen years," and has gained twenty-five pounds in weight. Dr. C. S. Boynton present at operation.

CASE V.—*Extensive chronic peritonitis.* Age 42. Abdomen nearly as much distended as at full term of gestation. Five pus cavities between the coils of intestine contained in all a quart of pus. Two cavities communicated by a common opening with sigmoid flexure of colon, through which pus had been discharging since last March. Separated adhesions in some places eight inches long. Abscess sac stitched to wound. Washed out cavity, peppered freely with iodoform, put glass drainage into sinuous opening, well down into colon. There were fecal discharges through drainage tube, and for several weeks after its removal. Patient cured returning to home Worthington, Ind., December 17th, 1887. Dr. L. P. Mullinix, of Worthington, present at operation.

CASE VI.—*Large pyo-salpinx.* Age 30. Patient lived twenty miles from city, and could not be brought to hospital. Pelvic peritonitis involving ascending colon, bladder, uterus, and numerous knuckles of intestine. Organs named were massed together as one, producing complete obstruction of bowel. Operation one of emergency. Separated enough adhesions to relieve obstruction, bowels afterwards acting freely. Death from shock in twenty-four hours. Disease of six months' duration. Earlier operating would, perhaps, have saved life, as patient was much reduced by long-continued vomiting. Dr. H. S. Herr, of Westfield, present at operation.

CASE VII.—*Peritonitis, extensive cobweb adhesions on nearly all pelvic organs, distending abdomen as much as a fifteen pound ovarian cyst.* Separated adhesions, letting out as much as three pints of pus from the different cavities formed by adherent bowels. Recovery. Dr. A. W. Patterson present at operation.

CASE VIII.—*Pelvic peritonitis involving all pelvic organs* Three sinuous openings in and near rectum, and one in vagina. Opened abdomen at night by coal oil lamp (being an emergency case). Drained cavity in broad ligament. Patient recovered. Dr. J. E. Morrow assisted.

CASE IX.—*Removal of ovaries and tubes for dysmenorrhea*, which had been accompanied by most excruciating cephalalgia. Patient had been in insane asylum for a year. Tubes sharply flexed and firmly held by contracting bands of inflamed peritoneal covering of tube and broad ligament; consequently tubes were immoveable, and absolutely impervious. Patient recovered from operation and is now sound mentally. Dr. A. Maxwell was present.

Of the forty abdominal sections made during the year ending May 10th, '88, in nine cases the pathological condition found had originated in *pelvic peritonitis;* hence the title of the paper, and the comments on pelvic inflammation.

Of my total year's work, sixteen sections were for abdominal tumors. Of this number four were for fibroids of the uterus weighing five, seven, and eight pounds respectively. One for fibroid of the ovary weighing six pounds. The remaining sections were for cystic and fibro-cystic ovarian tumors.

In a number of these cases, the tumors were large with extensive adhesions, notably one woman, whose weight in health was ninety pounds, traveled here from Oskaloosa, Iowa, with a cyst, which together with its contents weighed fifty-two pounds, adherent to entire anterior surface of abdomina wall as high as the liver on the right and the spleen on the left, so that absolute flatness on percussion was continuous with the organs named. First noticed tumor six years ago. She made a complete recovery, though I removed more than one-third of the combined weight of woman and tumor She had been tapped several times, the last tapping nearly proving fatal. In another case, the cyst and contents removed by tapping at the time of operating, and ten days before, weighed seventy-five pounds, the tumor being adherent to abdominal parietes and omentum. Patient could not be removed to my hospital, so I took an experienced nurse and operated at her home in Martinsville, Ind. She made a complete recovery, although she could not have weighed over seventy-five pounds after the removal of the seventy-five-pound tumor.

Two of my sections were cholecystotomies. Eight were for pelvic abscesses. Three were exploratory incisions, finding cancer in two of the cases. Ten sections were for removal of the uterine appendages in pelvic inflammation and other causes. One section was for hernia.

I have had three deaths from abdominal section during the year. One already reported. The second was an exploratory incision in a patient with forty pounds of fluid in the abdominal cavity, a ruptured cyst of left ovary, and well-marked mitral regurgitant murmur over heart. The fluid continued to pour out through drainage tube, patient dying seventy-two hours after operation, exhausted from the drain, and failure of the crippled heart. In the third case, a ruptured cyst with fifty pounds of fluid were found in the peritoneal cavity. Patient was in a hectic condition, vomiting for several weeks. Stomach retained fluid food after operation. She suddenly died from heart failure twenty-four hours after operation. This woman had taken over one hundred bottles of "Warner's Safe Cure," hoping thereby to remove her tumor! I saw the empty bottles in the backyard. Shall we not, in view of such cases in the State of Indiana, continue our missionary work of publishing cases to the end that we may convince practitioners, and they their patients, of the advantages of early operating, and the dangers and deaths from delay?

These forty cases, added to twenty-five reported to the Indiana State Medical Society last year, make a total of sixty-five. In my twenty-five cases reported last year, I reported five deaths, twenty per cent. of mortality. This year, in forty cases, three deaths or seven and one-half per cent. mortality. *From July 18th, 1885, to October 27th, 1887, I opened the abdomen thirty-four times consecutively without a death.* If by this showing some good woman's life (perchance a mother's) shall be saved by abdominal section, that otherwise, fearing the operation, would have delayed until there was no hope, the author will feel that the apparent self-glorification in this report is excusable.