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SOME REMARKS

ON ONE PHASE OF

PUERPERAL SEPSIS.

BY

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It is not my purpose in this brief report to say any thing on the subject of the prevention of puerperal sepsis. This has been fully set forth in the numerous communications on the subject in the last few years.

So fully have the profession mastered the prophylaxis of this dreaded malady, that a competent physician rarely ever has a case in his practice.

The midwives give us most frequently the opportunity of studying the treatment of "puerperal fever."

Nor do I propose to discuss the etiology of this disease. Suffice it to say that, in my opinion, it is fully settled that puerperal fever or septicæmia is caused by the introduction of specific poison into the genitals, where it grows and is absorbed or extends.

The morbific agent may enter the circulation from laceration of the perineum, vagina or cervix, or it may find its way to the cavity of the uterus, or tube, or peritoneum.

It may infect the entire organism, or be localized and form a focus of suppuration.

It seems, therefore, that, given a case of infection following labor, the indication is to ascertain, if possible, the location of the septic material and to remove it.

One condition in which this may be accomplished by early laparatomy is illustrated by the following cases which I will briefly report.

Case 1. Mrs. B. age 17, primipara. Was delivered Oct. 21st, 1890.

Three days later had rigor followed by fever, the latter continued until I saw her five weeks later. She was at that time thoroughly septic, temperature ranged from 103 to 104, pulse 100 to 120.

Examination revealed a tumor as large as a lemon to the left of the uterus. Section was recommended and with the consent of the family was done the next day, November 25th. The tumor proved to be an enlarged and thickened Fallopian tube, a coil of small intestine and

part of the sigmoid flexure of the colon, all firmly bound together by heavy exudate. In the center was about two ounces of pus. The adhesions were broken up and the tube removed. It was so friable that all ligatures tore out and the hemorrhage was stopped by the actual cautery.

The abdomen was washed out with boiled water, the incision closed with silk worm gut and a glass drain introduced.

Fever continued about two weeks. After that recovery was uninterrupted. She is now entirely well.

Case 2. Mrs. M., age 25, also primipara. Saw her first five weeks after confinement. Was attended by a midwife. She had fever all the time, but never very high. She suffered constant pain in the right iliac region. To the right of the uterus a tumor as large as the first was found. Operation December 11th, 1890.

The condition was almost exactly as the last case, large tube, ovary and coil of small intestine bound by adhesions, and in the midst an ounce or two of pus. The same difficulty with ligatures as in case 1 was experienced. Wound was closed and drained the same as case 1.

Recovery rapid and uninterrupted. Highest temperature second day 102.

The next case is somewhat different, but illustrates, I think, what might have occurred in the other cases, if they had been allowed to run their course without operative interference.

Case 3. The history is much the same as the others except that the septic condition was more pronounced. The fever ranged from 104 to 105, — there were rigors, sweats, and diarrhœa and great pain. The tumor was on the right side and reached as high as the umbilicus.

An incision was first made in the median line, in order, if possible, to remove the entire mass, but the adhesions were too extensive.

An opening was then made in the groin and a pint or more of pus was evacuated. Rubber drain was introduced. Recovery was very tedious.

I would not in another case, where the tumor was so large, attempt to remove it at all. The median incision gave us very little trouble, but it is quite difficult to prevent the infection of the wound in such a case.

I do not know how frequent such cases are.

We should, however, bear them in mind and not wash out the uterus to remove what is not in it.

Parrish says (*Gaillard's Journal*, October, 1890) that he has seldom in post-mortems found cases in which laparotomy would have been of service, but there are undoubtedly some such cases, but adds that it requires more skill to determine which cases should be subjected to section than to do the operation.

Baldy, Price, Woodward, Tait and others have reported cases in which they have done laparotomy for septic infection of the tubes and peritoneum. I have no doubt that many of the cases of pelvic abscess which run such a slow and tedious course could be entirely and quickly relieved by early laparotomy.

Where it is feasible we should always try to remove the diseased part since recovery is so much more rapid and probably more complete.

I do not feel justified from my very limited experience or what I have found in current literature, to lay down any positive indications for laparotomy in puerperal sepsis.

There are many cases in which the tubes are inflamed, or perhaps a tumor of the character found in my cases exists, which recover without operation or

the formation of an abscess which comes later to the surface.

These cases, however, usually make a tedious recovery and many of them are of the kind which were formerly diagnosed cellulitis. While some of them improve and perhaps eventually recover, the greater number remain more or less invalids. I remember well a case I had some five years ago.

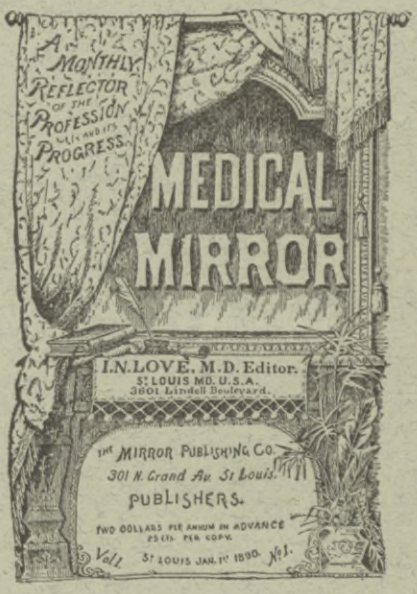
The symptons, fever, rigors, sweats all pointed to suppuration. The tumor was distinguishable.

She lay ten or twelve weeks in this condition. I thought pus had formed, but hesitated about operating. Eventually the fever and septic symptoms subsided without a discharge of pus in any way. The patient slowly improved, — the mass has now nearly disappeared, but she has never been entirely well since. I believe an operation would have saved her much suffering and she would now be in better health.

In closing I would repeat what I said in beginning, that puerperal fever or better sepsis is the result of an infection by a specific virus, and we are to seek out its lodging place. If we can find the location of the poisonous material, be it in the vagina, uterus, tubes or peritoneum, it should be removed.

Cases like those reported, in which the products of the infection are localized in the tubes, or in the peritoneum by adhesions, and the system kept in a septic state, the safer procedure is removal by laparotomy.

With proper precautions the mortality should be very small.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