McMURTRY (L.S.)

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Operation; Recovery.

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A CASE OF EXTRA-UTERINE PREGNANCY. OPERATION; RECOVERY.

By L. S. McMURTRY, M.D.,
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My purpose in reporting the following case is to illustrate some essential features in the pathology and symptomatology of extra-uterine pregnancy, and at the same time to emphasize the necessity of prompt operative interference. At our meeting in Washington last year this subject was more carefully considered and more thoroughly elucidated than in any previous discussion of the urgent questions involved. It is at the present time one of the most interesting and important practical subjects to which the attention of the profession can be directed.

Mrs. W. S. E., aged twenty-eight years, gave birth to her first child on the 8th of December, 1888. On the 8th of March, 1889, notwithstanding the fact that she was nursing, the catamenia returned. She also menstruated in April and May, but in June missed her period and exhibited some of the rational signs of pregnancy. On the 26th of June she suffered a violent paroxysm of pelvic pain. The pain was very severe, paroxysmal, and long continued. Very soon after this paroxysm uterine hemorrhage appeared. The flow varied at times as to quantity and was lighter than the normal menstrual discharge. This discharge, slight at first, increased in quantity on the following day. On the 28th a second paroxysm of pain occurred, less severe than the preceding one, and the uterine flow increased and continued for a week. Then there was a week free from pain and hemorrhage. The milk returned to the breasts and the patient arose from bed. At the end of a week she was again seized with a violent paroxysm of pain, and uterine hemorrhage recurred. For a week there was daily paroxysmal pain of diminished severity, when once again a period of apparent relief came. On the 27th of July she suffered pain of unusual severity, with symptoms of shock and collapse. On the 29th I was called to see her for the first time, and her husband, a prominent young physician of a Southern city, was summoned by telegraph. Having been at her bedside at the onset, her husband was lulled

into an over-confident security by the apparent relief which followed the first paroxysm, and had returned to his home and duties. From him I obtained the very accurate history of the case detailed above.

I found the patient pale and feeble from loss of blood, with pinched features, rapid pulse, and serous vomiting. The abdomen was distended and tender, and the lower limbs drawn upward. The uterus was pushed to the left side, and the bloody flow continuous. I proposed immediate operation, which was performed on the morning of July 30th, after consultation with Drs. William Huffman and Bush, of Lancaster, Ky., who were in attendance, and gave me every possible aid in the operation and care of the patient afterward. Dr. J. B. Kinnaird, of Lancaster, was also present at the operation and rendered valuable assistance. On opening the abdomen large blood-clots presented; the pelvis was filled with clot. This was quickly turned out, and I sought the fundus uteri with my fingers. The fetal ball was found on the right side, with ruptured tube. All was securely tied away and removed, the abdomen cleansed with hot water; drainage-tube inserted and abdomen closed. Length of incision three inches; patient on the table thirty-four minutes. Nausea and vomiting, which had been conspicuous and distressing symptoms for two days preceding the operation, persisted for twenty-four hours, but subsided and disappeared after the bowels were thoroughly moved by several small doses of calomel.

The progress of the case was uninterrupted. The drainage-tube was removed on the fourth day, and convalescence was prompt. The lady is now quite restored to health.

I here present for examination by the Fellows of the Association the fetal sac, with placenta, and the Fallopian tube and ovary.

Recalling the history of the case as I have related it, you will see that the first attack of pain was from rupture of the Fallopian tube. Then there was a respite from pain and apparent relief for a time, when the fetal sac broke, as shown in the specimen, allowing the fetus to escape into the abdomen, and filling the abdomen with blood.

The great practical lesson conveyed by this case is, that the medical attendant should urge prompt interference by abdominal section in cases presenting these symptoms. An entire month elapsed between the time this lady was first attacked with violent paroxysms of sickening pelvic pain and the operation for her relief. The operation was then performed upon an exsanguinated patient, with peritonitis established. When the diagnosis is questionable, the trivial risk of an exploratory incision is not to be compared with the immense peril of delay.

A London weekly of recent date announced that three operations

for extra-uterine pregnancy had been performed during the week in one district of the metropolis. A distinguished Fellow of this Association, within two years past, has operated in sixteen cases. Formad, of Philadelphia, states that within a brief period of his service as coroner's physician he found, post-mortem, nineteen deaths from ruptured tubal pregnancy. From these facts it is apparent how frequently this condition obtains. In this great country of ours, with its teeming millions scattered over the vast area of the States, who can approximate the number of women dying annually of ruptured tubal pregnancy, diagnosticated and treated as "idiopathic peritonitis," "accidental hemorrhage," etc.?

In these cases everything as to results depends upon prompt surgical interference; realizing which, let us appeal to the great body of the profession to recognize this important advance in pelvic surgery and rescue the patient by abdominal section, instead of consigning her to the so-called conservative fate of opium euthanasia, toying with electricity, or applying expectant methods.