

A Case of Repeated Tubal Pregnancy.*

By ALBAN DORAN, F.R.C.S.

Surgeon to the Samaritan Free Hospital.

A. D., aged 32, was admitted into my wards at the Samaritan Free Hospital on February 3rd, 1903. She had been married for six years and was the mother of three children; the youngest was five years old, and she had never miscarried. Her last period occurred in the fourth week of November, 1902; on January 11th, 1903, there was a show of blood, which continued for ten days, with much pain. After ceasing for a few days it returned, and continued until admission. She applied to Mr. Butler-Smythe at the hospital; he made out the above catamenial history, and found that she had been subject since the cessation of the period to severe attacks of dragging pain in the right iliac region. At times she felt faint, and she declared that she had experienced a severe attack of syncope on December 26th, followed by two more in the first week of January. The patient was examined by Dr. C. Hubert Roberts and myself, and admitted into my wards.

I found out a family history of phthisis, and the patient had recently suffered from an acute pulmonary affection, said to be "pleuro-pneumonia." Eight years before admission pelvic inflammation followed her second confinement, but there was no further history of pelvic disease. The patient was pale and flabby and troubled with frequent cough. The mammæ were flaccid, the areolæ dark; no milk could be pressed out of the nipples.

The uterus was pushed somewhat to the left, anteverted, mobile and a little enlarged. In the right fornix was a rounded swelling of the size of a walnut, easily defined above and below on bimanual palpation. It lay very close to the uterine fundus, and was slightly tender. In the left fornix, which was free, strong arterial pulsation could be felt. Much powdery, dark blood came away from the uterus. The urine on the day of admission showed a trace of albumen, which disappeared after a day's rest. The evening temperature rose to 100° in the mouth three times during the first week in hospital. There was dulness over the right subclavian region, râles and friction sounds were audible at the left base and a few râles at the right base. After nine days' rest the pulmonary symptoms had greatly improved,

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and the swelling in the right fornix had almost disappeared. The show had already stopped for several days, and there was no more pulsation in the left fornix. I discharged the patient, but kept her under observation. Severe pelvic pains were felt for three days after her return home. Then they ceased, and the period appeared and continued perfectly regular and normal until December, 1903.

On December 17th the period set in when expected, but was attended by unusual pain. At first for a day or two before the flow began, the pain was chiefly felt along the front of the right thigh, but such was the rule in this patient's case. Then it settled in the left side of the pelvis, and apparently caused a bearing-down sensation in the rectum. Early in January, 1904, there were several attacks of vomiting ascribed by the patient to exacerbations of the pain in the left side, which continued, whilst the show of blood did not cease. She was re-admitted under Dr. Hubert Roberts into the Samaritan Hospital on January 23rd; her cough was at the time very troublesome, but the sputum, though full of staphylococci, contained no tubercle bacilli. I examined the case with Dr. Roberts, and found the uterus displaced to the right and forwards by a firm and rather tense swelling, which occupied the left fornix and rose above the pelvic brim into the left iliac fossa. The urine was free from albumen, the pulse 90, and the evening temperature rose over 100°. I kept the patient at rest for a fortnight; the cough diminished under suitable treatment. On February 6th I found that the swelling in the left iliac fossa was somewhat larger, but little or no blood came away. A few hours later pain set in, and the show began to increase. On February 9th, as these symptoms grew worse, I operated. Chloroform was administered in preference to ether by Mr. Morley. On opening the abdominal cavity I separated some coils of small intestine and the lower end of the omentum from the internal genital organs, to which they adhered by recent lymph. The omentum contained a very old, firm, dark-brown clot of the size of a cob-nut. About four ounces of soft, dark-brown clot occupied Douglas's pouch. The left tube was the seat of recent gestation; I removed it, but could not clearly distinguish the left ovary. The right tube was abnormally thick and elongated, and its ostium much dilated. I removed it with the right ovary. The ligature cut through the tissues of the tube, softened by inflammation, close to the uterine cornu. I covered in the exposed stump of the tube by sewing the serous coat over it.

On the seventeenth day after the operation the patient had a severe attack of sharp pain in the left iliac fossa, and felt the

menstrual molimen. The temperature rose from 99·5° in the morning to 102° in the evening, and on the next day a severe attack of epistaxis occurred. No show was ever seen from the date of the operation until the patient's death from phthisis thirteen months later. In May, 1904, an attack of pain in the region of the right stump set in, accompanied by vomiting. There was no further pelvic trouble, and the patient did well until she had a severe attack of her pulmonary complaint, which proved fatal in March, 1905.

Pathological Report of Parts Removed.

Dr. Cuthbert Lockyer has kindly prepared the following account of the appendages which I amputated at the operation:—

"The specimen consists of the left Fallopian tube, to which is adherent a blood sac, and also the right Fallopian tube and part of the right ovary, with the intervening mesosalpinx.

"The left tube is normal in size at its uterine cut end, but from thence it gradually expands, and finally communicates at its fimbriated extremity with an adventitious sac containing blood-clot. This sac so closely invests the tube as to appear to fuse with its peritoneal coat. The fimbriæ of the abdominal ostium, however, are to be seen at the junction of the sac and the lumen of the tube. The sac measures two and a half inches in its vertical measurement. It is torn and shreddy on its front aspect, and to its internal walls blood-clot is adherent. Under the microscope a portion of this clot is seen to contain degenerate chorionic villi.

"This is an example of peritubal hæmatocele.

"The right tube measures three and a half inches in length. It is not increased in thickness, and shows no naked-eye evidence of rupture. There is some old blood-clot adherent to its fimbriated end, and also to the mesosalpinx between the tube and ovary. In this clot no chorionic villi have been detected. The fimbriæ of the tube appear normal on microscopic examination. As free blood was found in the peritoneal cavity at the time of operation the clot adherent to the tube may have been the result of rupture of the left-sided hæmatocele. Serial sections have not been made, but as far as the pathological investigation goes, it affords no proof that this tube was the seat of gestation. The evidence must rest on the clinical facts alone.

"The right ovary contains a fairly recent corpus luteum, and adherent to this organ is a layer of organising blood-clot and granulations."

The interesting short communication read by Dr. Purslow at the

last meeting of this Society¹ induced me to submit the above report to your consideration. Tubal pregnancy occurred twice in one patient under Dr. Purslow's care, and on both occasions diagnosis was verified at an operation. In my case some may think that the first or right-sided pregnancy remains hypothetical, but the recurrence of tubal gestation in one patient has been repeatedly proved. Authentic cases were reported by Dr. Lewers in a paper read before the Society two years ago,² and other cases were recorded by several Fellows of the Society in the discussion on that paper. Ernst Runge's valuable article on ectopic gestation,³ published about the same time, includes references to papers by Weil and others on repeated tubal pregnancy. I may be permitted to mention Lesse's case,⁴ published just a month ago, when Dr. Purslow's communication was read. Lesse removed a gestation sac of the right tube, saving the ovary. A year later pregnancy developed in the stump of the right tube, involving the corresponding uterine cornu. It ruptured at the sixth month; Lesse extirpated the sac and found that the corpus luteum lay in the left ovary, not in the right, which he did not remove at the first operation. This case should be remembered, because the question of the removal of a sound tube, fellow to a tubal sac, to prevent a future tubal gestation, was raised in the discussion on Dr. Purslow's paper; but Lesse's experience shows that amputation of a tube is no insurance against pregnancy in its stump.⁵

I must not wander far, however, from the condition observed in my own patient, where pregnancy recurred, not in the same, but in the opposite Fallopian tube. The history, and the appearance of a very distinct swelling to the right of the uterus, which ultimately underwent great reduction in size, under my own observation, warrants the diagnosis of right tubal pregnancy a year before I operated for gestation in the left tube. The fact that no trace of any product of conception could be detected in the right tube is no proof that it was not the seat of pregnancy checked at an early stage many months before it was amputated. Clinical evidence has shown that

1. "Repeated Tubal Pregnancy: Abdominal Section on Each Occasion."

2. "Repeated Ectopic Gestation in the Same Patient," *Trans. Obstet. Soc.*, Vol. xlv., p. 418.

3. "Beitrag zur Ätiologie, Symptomatologie und Therapie der Extrauterin-gravidität," *Archiv. f. Gynäk.*, Vol. lxx. (1903), p. 690.

4. "Demonstration einer geplatzten interstitiellen Schwangerschaft in 6 Monate," *Zentralbl. f. Gynäk.*, No. 18, 1905, p. 554. The patient recovered.

5. We all know that the stump of a Fallopian tube may function perfectly as an oviduct. See Author, "Pregnancy after Removal of Both Ovaries for Cystic Tumour," *Trans. Obstet. Soc.*, Vol. xliiv., p. 231; Cripps and Williamson, "Two Cases involving the Question of the Site of Impregnation," *Ibid.*, Vol. xli.; also Meredith, "Pregnancy after Removal of Both Ovaries for Dermoid Tumour," *Brit. Med. Journ.*, Vol. i. (1904), p. 1360. Lesse shows us that an ovum may become implanted in a tubal stump.

when a gravid tube discharges an early ovum, it soon resumes its normal appearance; indeed, it may itself become the seat of a second pregnancy.

Lastly, as already observed, some authorities are of opinion that when a tubal sac is operated upon the opposite Fallopian tube should be amputated, even when healthy, lest it might become the seat of another abnormal pregnancy. I question; however, whether this practice be justifiable. I know of three cases of normal pregnancy in patients from whom I had previously removed a gravid tube.

CASE I. L.B., 22; left tube removed October 26th, 1897; child born early in 1899. Dr. J. H. Rodgers, of Cardiff, operated upon it for imperforate anus.

CASE II. C.G., 24; right tubal mole displaced to left side of uterus, removed December 2nd, 1899.⁶ Female child born at term, December 17th, 1900.

CASE III. E.F., 29; removal of left tubal sac, displaced to front of uterus, July 23rd, 1901.⁷ Female child born August 15th, 1902.

On the strength of this experience I am not in favour of sacrificing a normal tube.

6. "Tubal Mole; Fœtus three-quarters of an inch in length," *Trans. Obstet. Soc.*, Vol. xlii, p. 134.

7. "Tubal Gestation Sac entirely Anterior to the Uterus; Operation; Recovery," *Lancet*, Vol. ii. (1901), p. 723. The above hitherto unpublished after-histories of cases two and three are instructive. In some cases of repeated tubal gestation, where no operation was undertaken on the first occasion, the second pregnancy may have been seated in the same tube displaced to the opposite side.