

VI.

A Case of Acute Purulent Salpingitis in which the signs markedly simulated those of Ruptured Ectopic Pregnancy.

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CAPTAIN HILDICH LEICESTER recorded recently in these pages* two cases of ectopic gestation, in which the signs were very difficult of interpretation, and it has occurred to me that, as the following case presented difficulties in the opposite direction, it may be worth while to give some short notes of it.

The patient was an unmarried girl of 23, who was brought to St. Thomas's Hospital by the police, having been found in a fainting condition in the street. She quickly recovered from this, and on her admission was quite conscious, and able to give a history of her illness. Having previously been regular she had missed her last period, which should have occurred three weeks ago. By the patient's own admission there was reason to think that the cause of this was purely physiological. For six days she had had pains in the hypogastric region, and a hæmorrhagic vaginal discharge, and on the night of her admission, while walking in the street, she had been seized with an unusually severe attack of pain and had fainted. When seen by me about an hour after her admission, she did not present the appearance of a patient suffering from severe internal bleeding. There was no marked pallor, and the pulse was of fair volume and strength, and was beating 108 to the minute. The temperature was 99·6°. The abdomen was slightly distended, but nothing could be felt on palpation, and there was no dulness on percussion. There was present, however, a sign which is generally considered very distinctive of tubal bleeding, viz., marked abdominal tenderness just above the pelvic brim. Nothing could be felt on bimanual examination. The clinical history, with the supra-pubic tenderness, pointed so strongly to the probability of a leaking tube, that I decided to operate at once. No blood was seen on opening the abdomen, but the small intestine was noted to be injected, and on passing the hand into the pelvis a little fluid, apparently pus, was seen, but so little that for the moment this was not certain. On exploring the pelvis the uterine appendages of both sides felt quite normal, but on bringing the tube of the left side into the wound for inspection, pus was seen to be

* Two Cases of Early Ectopic Gestation, with some unusually misleading symptoms, September number, p. 220.

dropping from its fimbriated end. The tube was quite soft and pliable, but the fimbriæ were œdematous and deeply injected. The tube was, therefore, removed, a wedge-shaped incision being made into the uterine cornu in order to remove the uterine end; this was then completely closed by sutures. On bringing up the right tube an exactly similar condition was found and treated in the same way. Both ovaries were left. The pelvis was then sponged dry, as small quantities of pus were found in the lower part, and the abdomen was closed without drainage. Except for a slight stitch suppuration in the lower angle of the wound, the subsequent progress was entirely satisfactory. The temperature never reached 100°, and the patient left the hospital within three weeks.

On examining the tubes afterwards, they were found to be without adhesions; they were soft and pliable, and there was no thickening of the walls. The mucosa was slightly swollen and œdematous. Both contained some thick creamy pus. Smears and cultures of the pus were taken, and were examined by Dr. Dudgeon in the clinical laboratory. He reported that the smears showed large numbers of pus cells, but no micro-organisms, and that the cultures remained sterile. While the patient was in hospital the hæmorrhagic vaginal discharge ceased, and instead a profuse purulent discharge was present for a few days. This also was examined, but no gonococci were found in films or cultures.

The case is certainly most instructive in that so many of the cardinal symptoms of ruptured ectopic gestation were present. The patient, having run the risk of pregnancy, was three weeks over her time for menstruation, and had had attacks of abdominal pain with metrorrhagia, culminating in a fainting attack. The one thing missing is the one least often obtained, the history of the passage of a decidual cast. When first brought to the hospital by the police, that is, shortly after the fainting attack, her appearance was much more like that of a ruptured ectopic gestation than when I saw her later. She had by that time recovered considerably, so that it was evident that she was not still bleeding. I placed considerable reliance on the supra-pubic tenderness, and, I think, there is no question that the safest course was to explore.

In spite of the negative bacteriological examination, it appears to me that the most likely explanation of the case is that an endometritis of mixed gonorrhœal and pyogenic origin had been the starting point of the salpingitis, and that the metrorrhagia was due to the endometritis. The attacks of abdominal pain were evidently caused by the spread of the infection to the fimbriated end, and in all probability the acute attack which caused fainting represented the dripping of pus into the peritoneal cavity. Happily the infective properties of the pus were of a very low order, as shown by the trifling reaction it caused in the peritoneum and by the fact that cultures taken from the pus in the tube proved sterile.