A PLEA FOR THE EARLY AND CORRECT DIAGNOSIS OF ECTOPIC PREGNANCY.*

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It is not my intention to try to say anything new upon this important subject, nor attempt to call your attention to anything that you do not already know; yet mistakes are so often made in the diagnosis of this condition, by the attending physician, that it seems that further notes of warning should be given to prevent the recurrence of the sad results which are so frequent. The classical symptoms of ectopic pregnancy as given in the text-books are plain and definite.

THE SYMPTOMS.

Generally a married woman who has had one or more children, and who has been sterile for a longer or shorter time misses her period and has all the usual symptoms of pregnancy. In addition to these symptoms she usually has what is more important as an aid to diagnosis, paroxysmal pains occurring in the pelvis. The attacks may come on without any known cause. Sometimes they are provoked by some local cause, such as coitus or defecation. The pains may be slight, but oftener are severe; vomiting, pallor, perspiration, small rapid pulse and tenderness of the pelvis may all be present. These attacks may last from a few hours to a day or more, but when they subside the patient is comfortable. They seldom begin before the end of the first month. Several of these milder attacks may occur before one is severe enough to produce symptoms of collapse, or the very first attack may be of this severe type. During the time the patient usually has a bloody, shreddy vaginal discharge, and she thinks she is threatened with a miscarriage. A vaginal examination shows a baggy tender mass usually at one side, and posterior to the uterus.

OFTEN MISTAKEN FOR MISCARRIAGE.

A careful consideration of the above symptoms accompanied with a thorough vaginal examination should be sufficient to enable any physician to make a diagnosis; yet how frequently is the true condition of affairs overlooked and often the physician makes the same error as the patient—thinks she is having a miscarriage and cures the uterus, thereby increasing the already serious condition. Or, if the rupture takes place on the right side, the patient may be treated for appendicitis, by some one of those physicians who still believe that this latter disease is exclusively a medical one, and that the surgeon has no business with it whatever. When the usual symptoms are present and rupture occurs I am not aware of any disease in which the diagnosis can be more definitely made than in ectopic pregnancy.

I believe that in most cases a diagnosis can be made before rupture occurs, but I would not advocate the examination of all pregnant women to see if an operation is necessary; at least, not until the average physician is better informed on this subject than he is at present—fearful that too many healthy women would suffer from the ignorance of the physician or from his desire to increase the number of his operations.

MANY CASES ARE ATYPICAL.

Many cases do not follow the usual symptoms given above. One patient that came under my observation during the past year was 28 years old, had been married

three years and three months and had two children, 27 and 9 months old, respectively. She was at this time suffering from sepsis, due to rupture of an ectopic pregnancy which occurred one month previously. The patient nursed her first child until she felt life with the second pregnancy, and was nursing the second child when I saw her, although she had a temperature of 103 F. In this case I was unable to obtain any history of a rupture, and the other symptoms were vague and indefinite, although the physical signs were characteristic. Following an operation she made an uneventful recovery.

In another case that I saw a few months ago the patient was 27 years old, married five years; six months before I saw her she had a miscarriage at three months, and one month before she had an attack of severe pain in the right hypochondriac region, almost producing collapse—no jaundice, but was sore and tender over the liver for about ten days. She was said to have had no rise of temperature. During that time and following it the pelvis was tender and sensitive. She said her periods had been regular and normal—not delayed or scanty. Physical signs indicated a mass posterior and at the right of the uterus, which was thought to be a ruptured tubal pregnancy. I was, however, sure it should be removed, whatever it might be. Operation showed the condition to be as expected and the patient made an uneventful recovery.

It has been my lot to see several cases of ectopic pregnancy in the unmarried, but I have never seen a case when the hymen was unruptured as reported by Webster.

In three of these cases the symptoms were very obscure as far as they could be learned from the patients. Some allowance was made for the statements of the patients, as I have found it the tendency of the unmarried in this condition to endeavor to cover everything suspicious. The physical signs were characteristic and operation showed the diagnosis to be correct.

CONCLUSIONS.

These cases are briefly mentioned to show that many do not have the history, the symptoms, nor even all the physical signs which we have been taught to believe are classical and always present.

There is, however, less excuse for a mistaken diagnosis in ectopic pregnancy than in almost any other abnormal condition within the pelvic cavity, if a history of the case is obtained and the patient carefully examined.

Usually it is not difficult to make the diagnosis, even before rupture occurs. In these cases the enlargement has a soft, elastic feeling, unlike almost anything else. When rupture does occur, if the attending physician can not make a diagnosis, he should call on someone who can and should not allow the patient to suffer for a long time or lose her life through hemorrhage or septic infection.

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DISCUSSION.

DR. PHILANDER A. HARRIS, Paterson, N. J.—It is true that a considerable proportion of cases of ectopic gestation I have seen have been curetted before they fell into my hands. It is a common mistake and arises from the fact that the patient has had a metrorrhagia for some time. The old descriptions of ectopic gestation or rupture will not answer for all cases, perhaps for only 20 per cent. If the tube in a tubal gestation ruptures near the uterus, the hemorrhage is very sharp and rapid; the patient has a rapid pulse, and the loss of blood into the peritoneal cavity may be sufficient to produce fainting. In a small percentage of cases we find all the classical symp-

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toms. If we were to rely simply on the old descriptions, we would, however, overlook four-fifths of the cases. The primary pain may sometimes be very slight, perhaps only a few ounces of blood may be lost, when no material increase in pulse will occur. We must bear these cases in mind as the old classical description will not answer for them.

DR. RUFUS B. HALL, Cincinnati—We occasionally see cases with a history so very different from that of a typical case that there is some excuse for the general practitioner. I quite endorse what the Doctor said about the cases that come for operation, because of repeated attacks of hemorrhage. I have a case in mind that was operated on eight or ten weeks ago, 35 years old, married. She was very anxious to have children. She had a catarrhal endometritis and for eighteen months her family physician had made local applications, given her tonics, massage and everything possible to build up her general health. Her menstruation was very irregular, and was frequently accompanied by a very severe pain. Her physician was obliged to give her a hypodermic of morphin so that she could sleep. After the last menstruation, nearly nine weeks elapsed before the menstrual period again came on. She had very severe pain, and had to have a hypodermic. The flow stopped, but began again nine days afterwards, and the doctor gave her another hypodermic. Three weeks later she went to bed with a third attack. There was no collapse. The doctor examined her very carefully, but found no swelling in or near the uterus. The bleeding continued. Repeated examinations were made, and after eight or ten days he noticed boggy tissue behind the uterus. He suspected ruptured tubal pregnancy. Thinking that she was aborting, he gave her an anesthetic, and curetted. He could not get the consent of the family to an operation until three weeks later, when infection set in and she had to be operated on for ruptured tubal pregnancy.

DR. L. H. DUNNING, Indianapolis—I agree with the speakers that not every case of ectopic pregnancy can be diagnosed, as the classical symptoms are not always present, especially in the ampullar variety. I have encountered two cases of this sort, where the patients had several hemorrhages, and ectopic pregnancy was not suspected until infection of the clots set in. Some years ago, while visiting a neighboring state, I met one of my friends, who asked me to come to his house to witness an operation for what he believed to be a tubal abscess. Three other physicians had examined the woman and confirmed this diagnosis. He opened the abdomen, and to the great surprise of everybody found an ectopic pregnancy which had ruptured three weeks previously without much hemorrhage. Subsequent infection gave rise to fever, and rapid growth of the tumor, and all the symptoms of pelvic suppuration. We often make a mistake if we attempt to lay down dogmatic statements for every case of ectopic gestation.

DR. C. L. BONIFIELD, Cincinnati—Within the last six months I have seen one case where I confirmed the diagnosis made by a general practitioner, and also confirmed by my colleague, Dr. Zinke, not one of the three knowing what the other thought. The diagnosis was made before rupture occurred. My interne in Christ's Hospital since last Christmas diagnosed two cases of ectopic gestation, one before rupture and the other at the time of rupture, so that I think extra-uterine pregnancy is now frequently diagnosed by men who are not specialists, not gynecologists. A number have said that hemorrhage often-times is not fatal in the first rupture. I believe there are many cases of ectopic gestation where we have hemorrhage that is not fatal to the patient, but is fatal to the life of the ovum, and these cases are not only not diagnosed at the time, but go on to complete recovery without ever being recognized.

DR. INGRAHAM, in closing—I did not say that the diagnosis can be made in every case, yet recurrent paroxysmal pains in the pelvis certainly constitute an important symptom. If the woman gets gradually worse, we may not be absolutely sure of ectopic pregnancy, but we are certain that there is something in the pelvis that should be removed. By making a vaginal examination a mass can usually be felt. When a case goes along like that mentioned by Dr. Hall, something should be done. We should not let the woman go on and die without

doing anything. The diagnosis can not always be made, but we can make out that the patient needs operative interference.

CESAREAN SECTION MADE NECESSARY BY A VENTROFIXATION.*

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Cesarean sections are not so numerous that any case is uninteresting or should not be reported even if success has not attended the efforts made for relief. Even want of success has its lessons and much may be learned which can be made profitable if heeded.

THE DANGERS OF VENTROFIXATION.

Much of value has been written in later years by such eminent authorities as Edebohls, New York; Burrage, Boston; Kelly, Baltimore; Noble and R. Wood, Philadelphia, and others as to the damages of ventrofixation in the child-bearing period, and yet the lesson does not seem to have been learned that ventrofixation during this period may become a very dangerous complication in pregnancy. The train of symptoms, for which women consult gynecologists, which require the operation of ventrofixation, are so well known that it is not necessary to recall them, and yet, would it not be better to allow a woman suffering from prolapsus uteri, cystocele, rectocele and pain in the back, to continue to suffer at least during the child-bearing period, or at most resort only to other modes of relief such as the Alexander operation or the various vaginal operations—not vaginal fixations however—rather than jeopardize her life by a ventrofixation, done without that very necessary accompaniment, viz.: removing the adnexa, and thus preventing the train of disastrous possibilities which follow. In order to show that this is no fancy sketch of the dangers which follow this operation in the child-bearing period, it is only necessary to recall a few facts as recorded.

Milander has collected 54 confinements at term after ventrofixation with 11 difficult labors; 4 forceps; 2 Cesarean sections; 2 podalic versions; 2 transverse presentations; 1 foot presentation, making no mention of the fetal loss. Of this whole number of pregnancies after ventrofixation, 74 collected by Milander, 6 terminated in abortion; 3 by premature delivery; 10 were still pregnant, and no one knows the conditions resulting, and no one knows how many of the operations for ventrofixation were absolutely so complete as to prevent the tearing loose of the uterus which would have removed the danger.

THE CASE IN POINT.

With these preliminary remarks the writer wishes to put on record the following case.

Mrs. A. S., aged 43, American, had three children, aged 19, 17 and 15 respectively. Was taken in labor Dec. 6, 1901, pains increased gradually, and on December 7 the membranes ruptured. She continued to have pains, gradually increasing in number and severity. On December 11 the attending physician took another physician with him and administered chloroform for the purpose of doing version. On attempting this he found that the cervix could only be reached after introducing the hand and forearm up to the elbow. The cervix was not patulous, and no presenting part could be outlined. At this stage it was learned that the patient had had, seven years before, a perineorrhaphy and ventrofixation, and that since that time she had aborted once at three months. A surgeon was called and found the conditions as above stated.

Externally, the patient presented an irregularly enlarged

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