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A Case of Tubal Abortion in which Growth of the Fœtus Apparently Continued after the Formation of a Hæmatocele.

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THIS case is recorded as an instance of the difficulty in recognizing the continued growth of the ovum in cases of tubal gestation which have resulted in hæmatocele formation. The patient was a woman of 34, who had had one pregnancy nine years ago. Menstruation was of the 28-day type and lasted four days, and had been quite regular up to May, 1906; but the period due on June 3rd did not appear at the expected time. A week later the patient was seized with a severe attack of pain in the left iliac region, followed in a few hours by some uterine hæmorrhage. A few days later there was a second and more severe attack during which she fainted several times; slight hæmorrhage also accompanied this attack, and continued throughout her illness, coming on for two or three days and then ceasing and returning again. She was confined to her bed or bedroom for five or six weeks under the charge of her medical attendant, during which time the pain gradually disappeared. At the end of July her doctor examined her and found "the uterus large and absolutely retroflexed, the fundus pressing firmly down on the pelvic floor," and under anæsthesia he endeavoured to replace what he took to be a uterus about three months gravid. During August the patient was able to get about and on the 20th she went to Weston-super-Mare to recruit. On the 22nd the hæmorrhage ceased, but while she was out for a drive on the 23rd it recurred more profusely than before. On reaching home she found she had passed something that she described as being like a piece of skin about the size of the palm of the hand. In consequence of this attack she was brought back to London on August 26th. On her return, she at once took to her bed as the pain was again severe. On September 1st she had another attack of pain with flatulence and great abdominal tenderness, and on the 2nd this was worse. Her medical adviser found the abdomen distended, the pulse 110, and the temperature 100°. Looking on the case as one of peritonitis, he sent the patient up to St. Thomas's Hospital shortly before midnight with a view to immediate operation.

On admission, the patient was pale and looked ill; the temperature 102.4° , pulse 120 and weak, respirations 28. The abdomen was slightly distended and, below the umbilicus, did not move at all on respiration, whilst in the upper part the movement was very deficient. On palpation there were marked rigidity and tenderness even on very slight pressure, especially on the left side of the lower part of the abdomen. Bimanual examination was almost impossible owing to the rigidity and tenderness, but it could be made out that the uterus was fixed; there was also some fulness in Douglas's pouch with an ill-defined boggy swelling filling up the left side of the pelvis. As the nature of the case appeared to be quite clear, and as the rapid development of acute symptoms indicated the need of immediate operation, the abdomen was opened at 1 a.m. on September 3rd. The omentum and underlying pelvic viscera were matted together by recent adhesions, so as to suggest at first sight that the condition was due to an inflammatory process rather than to an ectopic pregnancy. There were flakes of yellow lymph among the adhesions, and during the separation some dirty, almost purulent, fluid escaped. Unfortunately, owing to the urgency of the case and to the time of night at which the operation was done, no preparations were made for a bacteriological examination, and hence it is impossible to say whether there was any infective process present. The uterus was easily defined, lying forward in the middle line, with a large swelling behind it and the left broad ligament. On separating it from the surrounding structures this swelling was found to be made up of the left Fallopian tube and a hæmatocele sac. The sac and contents were removed with the left uterine appendages, but in the process the sac was ruptured and a foetus and a mass of placental tissue with much old blood-clot were removed separately. The ragged cavity left in the pelvis was dry sponged, and as there was some question as to whether it might not be infected, a gauze wick was brought through the lower angle of the wound. The patient made an uninterrupted recovery and was discharged from the hospital on September 22nd.

The chief interest of the case lies in a study of the parts removed at the operation in relation to the clinical history. The Fallopian tube was thickened and tortuous in the inner and middle thirds, both muscle and mucous membrane being involved. On slitting it up this was also shown by the presence of "bridges" at the site of the kinks, as seen in chronic salpingitis. It contained some dirty blood-stained fluid. The outer third of the tube was dilated to about the size of a finger, the ostium was widely patent and the fimbriæ could be traced out on to the wall of the fibrinous sac with which they were intimately blended. Owing to its ragged state it was difficult

to estimate the size of the sac, but it appeared to be approximately equal to that of a Jaffa orange. An irregular ovoid mass about equal in size to a duck's egg was removed with the blood from the sac. It consisted of placental tissue and blood-clot; the amniotic membrane was seen quite plainly on one surface and to its periphery was attached the stump of the umbilical cord. With this mass was a fœtus measuring 13 cm., with 12·5 cm. of umbilical cord attached to it. Its head, trunk, and limbs were quite perfect, and though it was somewhat discoloured it showed no signs of decomposition. No offensive odour was noted from the material removed.

Unfortunately, it was impossible, owing to the rupture of the sac, to be certain of the exact relations of the fœtus and placenta to the sac, but both were contained within the adventitious capsule and were only seen after its walls had given way. It was quite certain that both were outside the tube, and indeed they were both too large to be contained within it.

Reading these findings into the clinical history it appears probable that this patient had an ectopic gestation in the left Fallopian tube and that, after missing the period due on June 3rd, she had, about a fortnight later, all the symptoms of a tubal abortion with intra-peritoneal hæmorrhage. The ovum could not at the time be of more than six weeks' development. In the latter part of July she evidently had a pelvic hæmatocele, which her medical attendant mistook for a retroverted gravid uterus, and which he made an attempt to replace. Then, after a month, during which her condition had so far improved as to allow of her being sent a considerable distance to the seaside, a sharp attack of uterine hæmorrhage occurred, with the passage of a uterine cast, and as this corresponds to the stage of development of the fœtus of 13 cm. found at the operation, it may be taken to mark the date of death of the fœtus. Counting the pregnancy from the last period in the beginning of May, the passage of the cast on the 26th of August would make the age of the fœtus close upon sixteen weeks or thereabouts, and this corresponds fairly closely with its age as calculated from its length.

This case, then, is of some clinical interest as showing that in spite of the formation of a pelvic hæmatocele followed by a subsidence of symptoms, an ectopic pregnancy may continue to develop without giving definite signs of its so doing. Even if this were an unusual occurrence, the knowledge that it may occur and that it may at any moment give rise to a secondary rupture is sufficient to make the expectant treatment of such cases appear hazardous, unless the patient is kept under very close observation and is under such conditions as would allow of immediate operation should an operation be required. Had a secondary rupture occurred in this case

during the journeys to and from Weston-super-Mare, the consequences might have been extremely serious.

The rapid development of serious symptoms after the supposed death of the foetus on August the 26th is not easy to explain. In the absence of any bacteriological examination, it is useless to speculate as to the possibility of the sac having been infected, but the clinical symptoms and the appearance of the abdomen when first opened were suggestive of a local peritonitis. The condition of the inner part of the left Fallopian tube was indicative of old inflammation, and possibly the travelling and moving about of the patient were sufficient to stir up an attack of pelvic peritonitis.