Lecture

ON A

CASE OF RUPTURED TUBAL PREGNANCY.

Delivered at Queen's College, Birmingham,

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GENTLEMEN,—The preparation which I now pass round was removed by abdominal section this morning from a patient, aged twenty-seven, residing at Ilfracombe, and it illustrates a new point in the pathology of ruptured tubal pregnancy, most of the facts of which, as known to me, have already been brought under your notice. The patient in question was twenty-seven years of age, had been married six years, and had never been, so far as she knew, pregnant, this being not unfrequently a leading feature of these cases. She had menstruated with perfect regularity until Christmas, then she had missed till March, and during the whole of that time she had been confined to bed with what was called inflammation of the womb, and was attended during that illness by a well-known practitioner in Liverpool. At the beginning of March she had so far recovered as to be able to get up for a short time, but on the second day of her getting out of bed she was suddenly seized with acute violent pain, and was kept in bed again for three weeks with what she said to be, and what clearly was from her description, an attack of acute peritonitis. Early in April she returned home to Ilfracombe, and was then seen by Dr. Slade King, who recognised the fact that there was a tumour on the left side of the uterus. In April she had an attack which she described as being very like a recurrence of the peritonitis that she had in the previous month, and there have been two or three attacks since then more or less severe. She has menstruated twice for a fortnight each time, the loss being very profuse and the pain extremely severe. When I saw her on July 4th, she was emaciated, in constant pain, quite unable to get about, and evidently suffering from the presence of pus in the pelvis. Examination revealed a tumour quite as large as a foetal head on the left side of the pelvis, fixed and extremely tender to touch. Such a history gave no clue whatever to what proved to be the real nature of the case; for even the suspension of the menstrual flow from January till March was precisely what might have occurred in a case of hæmatocele of the broad ligament, or in several other conditions which might have been referred to as an explanation of this case. Certainly, in the minds of those who gave the history the suspicion of pregnancy had never been entertained, and my own diagnosis did not include a differential suggestion in the direction of tubal pregnancy; it was given as that of suppuration of the left Fallopian tube. That diagnosis proved to be perfectly correct so far as it went; but, to be complete, it ought to have been extended to include suppuration as the result of ruptured tubal pregnancy. Such an extension, however, with the facts before me, did not occur to me.

The state of the patient was such as to demand immediate interference, and therefore I opened the abdomen and found a state of matters the details of which were easily ascertained, and were as follows. The omentum was glued over the contents of the pelvis, and I had a little difficulty in detaching its fringe from the base of the bladder. After I had done so I found several coils of intestine adherent below it, and on removing these I at once opened up a cavity, from which escaped a quantity of extremely fetid purulent fluid. This cavity was as large as a Jaffa orange, and the first thing that I came in contact with was a large mass of easily detached substance, recognised at once by my fingers as a piece of placenta. I removed it, and the naked-eye appearances confirmed what I had uttered about it before I removed it. I then easily recognised that the cavity from which I had taken it was formed of the dilated and distended Fallopian tube, forming the anterior, posterior, and lower walls of the cavity, whilst the upper part was composed of the coils of intestine and omentum, which I had partly detached. All round the cavity I could feel a number of sharp, hard points, and these I easily recognised

as foetal bones embedded in the walls of the cyst. I removed as many of them as I could, and found that they were what I had believed them to be, for included in what I removed were a number of foetal ribs and flat bones. I then proceeded carefully to detach that part of the cyst formed by the Fallopian tube, and when I had done so I tied the pedicle and removed what you now see before you. The presence of fimbriae proved conclusively the accuracy of my supposition.

We have here, then, a case of the greatest possible interest, for it proves what certainly has not been completely established up to the present time, that rupture of a tubal pregnancy into the peritoneal cavity may not be fatal at the time of rupture by reason of recurrent hæmorrhage. There is one case quoted by Campbell, and originally narrated by the late Mr. Samuel Hey of Leeds, in which I think it is possible to accept this conclusion as very nearly proved; but the difficulties of a certain diagnosis of ruptured tubal pregnancy are so great that without the complete proof, which can be obtained only from a post-mortem examination or an abdominal section, it is very easy to throw doubt upon any such record. Here, however, we have absolute proof of the occurrence of tubal rupture into the peritoneal cavity, not only without a fatal issue at the time, but apparently without the occurrence of hæmorrhage. It is probable, however, that such cases are very rare. Without this fatal incident of hæmorrhage it is not difficult to believe that the whole contents of the tube may be absorbed by the peritoneum, as the foetus was in process of being absorbed in this instance; and but for the occurrence of suppuration, it probably would have been so completely absorbed in a few months that no trace of its existence could have been recognised. The facts, however, that in nature's own process of cure an interruption by suppuration occurred, leading to such extreme peril that the patient escaped narrowly at least three times from peritonitis, and that if she had been left alone long her death from the recurrence of this trouble would have been absolutely certain, shows completely that it is not safe to leave these cases to a natural termination.

It is impossible to imagine that the Fallopian tube could ever have resumed its functions after being submitted to such an accident as this, and it is not difficult to believe that for months after, if not for years, it would have continued liable at any moment to the suppurative process which you see here had taken place. The patient has made an easy recovery, and under these circumstances, and with a growing experience of the small fatality resulting from this operation, I unhesitatingly recommend the removal of the Fallopian tube, together with the remains of the pregnancy, in every instance. The further interest of the case is that I am bound now to add another subdivision to the scheme of ectopic gestation which I have already submitted to you, and therefore I give you the amended table, as follows:—

Scheme of Ectopic Gestations in Tubo-ovarian Tract.

1. Ovarian; possible, but not yet proved.
2. Tubal, in free part of tube; and is—
 - (a) Contained in tube up to the fourteenth week, at or before which time *primary* rupture occurs, and then the progress of the gestation is directed into—
 - (b) Abdominal or intra-peritoneal gestation, uniformly fatal, unless relieved by abdominal section, primarily by hæmorrhage, secondarily by suppuration of the ruptured sac and peritonitis.
 - (c) Broad ligament or extra-peritoneal gestation.
 - (d) May develop in broad ligament to full time, and be removed at viable period as a living child.
 - (e) May die and be absorbed as extra-peritoneal hæmatocele.
 - (f) May die, and the suppurating ovum may be discharged at or near the umbilicus, or through the bladder, vagina, or intestinal tract.
 - (g) May remain quiescent as lithopædia.
 - (h) May become abdominal or intra-peritoneal gestation by secondary rupture.
3. Tubo-uterine or interstitial is (a) contained in the part of the tube embraced by uterine tissue, and, so far as is known, is uniformly fatal by intra-peritoneal rupture (as b) before the fifth month.

The above scheme gives a complete consistent story of the pathology of ectopic gestation, so far as I know it, and it certainly removes an enormous amount of the confusion which has hitherto existed concerning it, and many of the difficulties encountered in the treatment.