Case Reports

COINCIDENT RUPTURED ECTOPIC GESTATION AND ACUTE SUPPURATIVE APPENDICITIS*

BY CHARLES E. RUTH, M.D., F.A.C.S., DES MOINES, IOWA

Cases such as this are rare enough to be well worth reporting, presenting difficulties too, in diagnosis, which makes them interesting. In over thirty years of dealing with these conditions I have never before seen them occur coincidentally, so consider myself fortunate in making the diagnosis before operation.

The patient, Mrs. S., twenty-three years old, family history negative and general health good. She aborted in the summer of 1920, but recovered without incident. In October she menstruated normally but failed to menstruate at all in November. On December 7, she had an apparent attack of appendicitis accompanied by a slight menstrual flow, from which she recovered sufficiently to be about and at her work in three days.

Jan. 8 she was again taken suddenly ill. Her family physician, Dr. R. Fred Throckmorton, was called at two in the morning. She was in profound shock, pale, nearly pulseless, abdomen tender, rigid and distended with gas. Ordered to the hospital immediately, she did not arrive until late afternoon.

At ten in the evening of the same day her pulse, still weak, was markedly improved. She was no longer in severe shock. At this time her temperature was 101° F. Leucocytes 17,000. Pain, still severe, was more marked on the right side, as were also tenderness on pressure and muscular rigidity. Behind the uterus a mass filled the pelvic cavity.

Presumptive diagnosis of ruptured tubal pregnancy and acute appendicitis was made. Operation was postponed until morning, improvement from the shock seeming to indicate that hemorrhage had ceased and that further improvement was likely. Improvement did continue during the night so that she reached the operating room at eight o'clock in very fair condition.

Median incision below the umbilicus revealed the upper abdomen filled with pus, the lower abdomen and pelvis containing a large amount of partly coagulated blood. The right fallopian tube was found to be ruptured. It contained a placenta with attached cord and a three inch fetus. The tube was ligated, removed, and the stump covered with peritoneum. The pus in the upper abdomen came from a retrocecal appendix which was covered with a thin film of exudate. There seemed to be no attempt at limitation of the infection by adhesions of omentum or intestinal loops. The stump of the appendix was too thick and brittle to be ligated, but was inverted by suture. One large drainage tube was placed in the culdesac of Douglas and another behind the cecum.

The operation was concluded with as great speed and little exposure and trauma of tissue as possible. Postoperative condition fair. The patient was kept in a sitting position well inclined to the right. Proctoclysis was continuous. The wicking in the drainage tubes was removed at the end of twenty-four hours.

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Recovery was complete in four weeks at which time she was up and feeling well.

It is not always easy to decide in cases such as this, whether to operate immediately or wait until conditions are a little more favorable. I do not like to operate at night. I feel that I do better work in the day time. Except in cases where it is quite apparent that the progress of the case is backward and delay dangerous, I prefer to wait until morning.

In this case we did the proper thing for she rallied from the shock and came to the operation in better shape than she would have the night before. And yet there was always the possibility that hemorrhage would recur or that she might have by morning absorbed enough of the toxins from the appendix to be beyond help. The latter danger we decreased by keeping her on her right side with the shoulders elevated, throughout the night. The danger from hemorrhage was lessened by limiting her movements with morphine and placing of an ice pack on the lower abdomen. The constant improvement during the night was not an absolute indication that we were safe. A hemorrhage might have occurred at any moment.

Twenty years ago suppurating appendicitis with diffuse peritonitis resulted in a mortality of about 90 per cent. Now 10 per cent is not expected, other complicating factors, such as we had in the case reported, being absent. The principal factors in reducing the former great mortality are, I think, five: (1) shorter time of operation; (2) continuous proctoclysis to supply the needed body fluid while the stomach is irritable; (3) Fowler position to aid drainage and prevent infection from gaining contact with the open mouthed lymphatics of the upper abdomen; (4) less trauma from atmospheric exposure, manual manipulation and contact of peritoneal surfaces with dry gauze; and (5) well placed, large drains.

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(For discussion see p. 534.)

DOUBLE UTERUS AND VAGINA*

BY DAVID HADDEN, M.D., F.A.C.S., OAKLAND, CALIFORNIA

IN December, 1919, Miss E. S., nineteen years old, consulted me because of indigestion and loss of weight following influenza. Her last menstrual period had occurred in May, though prior to that time she had menstruated regularly every 20 days since the beginning of her menstrual life at thirteen years. The only symptom referable to the pelvis was a heaviness in the lower abdomen.

External pelvic examination showed a normal introitus. On digital examination it was found that a cystic mass bulged from the right side into the vaginal canal. It began one inch from the hymen and extended to the right of the cervix and above its level. It was of sufficient size and tension to make examination of the cervix and uterus difficult. The uterus appeared to be of normal size; the cervix was normal but congested. The cystic mass was not tender.

A diagnosis of a probable cyst of the duct of Gärtner was made because of the normal outlet and the level at which the cyst had its origin.

Following a few local treatments and organotherapy, the menstrual function was established and continued regularly without distress of any kind.

In November of 1920 the girl was married. About Dec. 25, I was called to her home to find her suffering with acute peritoneal irritation and presenting the picture of pelvic abscess.

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