CASE OF COMBINED EXTRA- AND INTRA-UTERINE PREGNANCY.¹

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THIS case is one of some interest beyond the presence of the condition for which I have the pleasure of presenting it to this society tonight.

The patient, a woman twenty-six years old, in good circumstances, well developed, weighing 130 lbs., had been under my care for two years, with periodical attacks of hysteria, with convulsions of minor grade, and occasional attacks of hystero-epilepsy. These attacks were frequently of menstrual origin, but at other times were brought on by overindulgence in stimulants or from family disturbances.

There were two well-marked zones. One was in the region of the left eye, the organ being amblyopic and frequently congested. The second zone was over the region of the right ovary and was very hyperesthetic. Mild seizures could be induced at any time and severe seizures made worse by pressure on the zones. I had at various times given her treatment for ovaritis, the right ovary being considerably enlarged and tender.

Within the year previous to the pregnancy she had had two mild attacks of appendicitis, with slight temperature and considerable pain, each attack lasting about a week. With them there was no marked induration, but the appendix could be felt, swollen and rigid. The patient could not be induced to have an operation performed either during or following these attacks, although told of the dangers. It is a curious fact that, although practically springing from the hysterogenous zone, these symptoms were not accompanied by any hysterical outbreak.

She had been married five years. Her menstrual life had been fairly normal except for the occasional hysteria already spoken of, with little pain and no excessive hemorrhage. In her early married life she had one pregnancy, which ended in an early abortion, the cause of which I could not learn, but believe it was induced. She passed her menstrual period, due about Nov. 30, but had no nausea. There was some slight pain two weeks later, but not enough to require attention.

On Dec. 21, while riding in a street car, she had very sharp darting pains low down on the right side. These were cramp-like, but were easier while standing, so that she rode a little further in this position. As they grew worse, she took a carriage and drove to the house of a friend who was a physician. There she went to bed and was given a hypodermic of morphia, which relieved her. She had no fainting or nausea, no evidences of shock. She did have a slight chill, followed by a low grade of fever which lasted until I saw her at her home in Newton. No vaginal examination was made and no attempt at a diagnosis.

I first saw her on the evening of Dec. 24. She was not feeling ill and had no sensation beyond that of slight pressure and fulness low down on the right side. She said she had had another of

her appendicitis attacks. There was no nausea; the functions of the bowels and kidneys were normal. Temperature 100.6°, pulse 110. There was some tenderness on pressure on the right side, extending downward from about the sup. spin. process, with the centre just below the McBurney point. There was slight dulness on percussion over this region, but not well marked.

By the vagina the uterus was found in normal position, but a little high, fairly movable and enlarged. The ovary and tube of the left side were found normal. At the right side was felt an illy defined boggy mass, seemingly closely connected to the uterus, extending outward to the brim, and exquisitely sensitive to pressure. Pain was also caused by moving the uterus upwards or to the left.

It will be seen in this brief statement of the history of the case that the diagnosis was not altogether clear sailing. She had been sterile for several years, but none of the absolutely classical symptoms of extra-uterine pregnancy were present beyond this fact and that of sudden pain. There had been no bloody vaginal discharge, no decidua remnants. The uterus was absolutely enlarged and undoubtedly pregnant. It was not bound down or pushed to one side. The objective and subjective symptoms were all characterized by their mildness. The patient had had a chronic ovaritis. She had had two attacks of appendicitis and, to her feelings, this attack was much like the others. But, on the other hand, her ovaritis could not be responsible for the sharp pains with the boggy mass close to the uterus. A ruptured appendix with its inflammatory product would give more decided signs of its presence. A mild appendicitis might be present, but alone it could not be responsible for the whole train of symptoms. There could be no question of salpingitis. The character of the onset, the pain, the slight dulness on percussion, the peculiar feeling in the vault, led to the conclusion that what I had to deal with must be a hematocele. The cause of this I could not determine and so informed the patient. The possible conditions were fully explained and the need of immediate operation, but this she would not consent to.

Dec. 25. Condition was about the same, but the temperature and pulse had both subsided.

Dec. 28. The temperature was again 100° and pulse 110, and the pain was more marked.

I was now convinced of the condition existing, and after great difficulty she finally agreed to an operation the next day, which I did at the Newton Hospital. The incision was median, and on entering the abdomen a quantity of fluid blood with some clots escaped. This was not measured, but was estimated at between 20 to 30 oz. A mass of adherent tissue was broken through, and the bleeding point found to be in the right Fallopian tube, which was enlarged and ruptured close to the uterus. From the ruptured cavity there was some little fresh blood oozing. This was clamped and ligated; the folds of the broad ligament were infiltrated with blood and covered

¹ Read before the Obstetrical Society of Boston, Dec. 12, 1901.

with clots, which were removed. The ovary was found considerably enlarged and cystic, more than three-quarters of its structure being involved. This was also removed. The portion of the tube involved was less than one-half inch from the uterus, but the enlargement did not invade the uterus itself. Great care was taken not to disturb the uterus, in the hope of saving the normal pregnancy, but the ligature securing the tube had to be placed practically on the uterus itself, owing to the friable state of the tissues. The tip of the appendix was adherent to the ovary, the appendicular ovarian ligament being obliterated. The organ was swollen and congested, and was removed. After the usual washing out with saline solution the wound was closed.

The patient rallied promptly from operation, her highest subsequent temperature being 99°.

Having used such care in the manipulations, I had hoped to save the uterine fetus, but flowing and pain began on the fifth day after the operation, Jan. 3.

On Jan. 4, without ether, I dilated and curetted, removing the remains of an eight weeks' fetus. The uterus was swabbed out with iodine and packed with iodoform gauze, which was removed the next day, no symptoms developing.

The progress of the case was uneventful, and she left the hospital on the fifteenth day after operation. Her condition since then has been most satisfactory. She has gained in flesh and strength and control over herself, having had but two of her hysterical attacks in the last year, which were of short duration and light character.

In studying this case there are to me some interesting points. The uterine pregnancy and existence of other morbid conditions were elements tending to confuse the diagnosis, but I still cannot understand how the condition of hemorrhage present could cause so few subjective symptoms.

How small a portion of ovarian structure is required for efficient work was shown by the condition of the ovary removed. The intimate connection between the diseased ovary and the appendix was interesting as to the influence the former had in causing the inflammatory attacks of the other, which contained no concretion or fecal matter. Finally, the practical cessation of the hysterical outbreak which has followed the removal of the diseased ovary showed that this hysterogenous zone had a cause for being.

ACCORDING to a late report, cholera is epidemic in various parts of Asia. Over 100 deaths have occurred at Medina, and it is also very prevalent among the Chinese on an island opposite Canton. One European in Canton is said to be dead from the disease. The Hong Kong authorities are taking every possible precaution against it. A despatch from Melbourne states that all dirty blocks are being cleaned, rats are being destroyed and garbage is being burned, in order to prevent the further spread of bubonic plague, which is epidemic in parts of Australia.—*American Medicine.*

Clinical Department.

ACUTE LYMPHEMIA WITH ESTIVO-AUTUMNAL MALARIA.

BY PHILIP KING BROWN, M.D., SAN FRANCISCO, CAL.

PATIENT, A. R., male, 45 years old. Applied for treatment in September, 1896, giving a history of having lived for some years in a malarial country but without having contracted malaria. He had been in San Francisco but a few weeks, and had felt badly ever since his arrival. No history of any acute illnesses and no lues. He has used alcohol to excess for many years and smoked moderately. Complained of headache, malaise and fever, with irregular chills for some weeks. Prostration was extreme for a few days prior to the examination.

The patient's heart was dilated, the arteries were atheromatous, the urine contained a small amount of albumin with hyaline and granular casts. The liver was 14 cm. broad in the right mammary line, the spleen was easily palpable during inspiration, but not tender. There were no scars on body or penis. The glands were everywhere slightly enlarged, but not particularly tender. The skin was pale and there was a puffiness about the eyes.

Temperature at 11 A.M. 102°, pulse 100. Blood examination showed a leucocytosis of 40,000, 82% of the leucocytes being large lymphocytes. There were also a good number of estivo-autumnal parasites in the blood — ovoids and crescents.

The patient died in five weeks. My unfavorable prognosis sent him elsewhere for help, and I did not see him again.

The accompanying photograph shows a characteristic field.

Medical Progress.

REPORT ON DERMATOLOGY.

BY JOHN T. BOWEN, M.D., BOSTON.

(Concluded from No. 11, p. 289.)

ORTHOFORM ERUPTIONS.

Dubreuilh¹ reports two interesting cases of dermatitis from this drug. Orthoform has been generally considered innocuous, as large ulcerated surfaces may be covered with it, without causing any signs of intolerance. Its analgesic properties on surfaces denuded of epidermis are very marked, while, when applied to an intact skin or mucous membrane, its effect is slight or wholly wanting. The eruptions that may be caused by orthoform are either of an erythematous nature, complicated or not with vesicles and pustules, or gangrenous. The erythema may be limited to the vicinity of the part to which the orthoform has been applied, or it may become generalized over a large part of the body. It is not necessary that the orthoform be applied to a

¹ *La Presse méd.*, May 18, 1901.