

SECTION OF OBSTETRICS.

NOTES ON A CASE OF SUPPURATING OVARIAN CYST, COMPLICATED WITH A LARGE INTRA- PERITONEAL ABSCESS.

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THE following case is, I think, worthy of being brought to the notice of the Academy. It furnishes an example of a happily not very common complication of an ovarian cyst, and is for this and perhaps for other reasons of interest. Before proceeding to relate it, I must mention that I am not alone responsible for the good results with which its treatment was attended, but that it was a case the major credit for which belongs to our late President, Dr. A. V. Macan, who was the first person to operate upon the patient.

CASE.—Mrs. K. D., aged thirty-eight, was admitted to Sir P. Dun's Hospital, under the care of Dr. Macan, on July 27th last. The patient, at the time of admission, was in an extremely critical condition. She suffered from great pain over the abdomen, loss of appetite, thirst, vomiting, extreme constipation, and debility. These symptoms had been present to a marked degree for the previous five weeks, but prior to that time she stated that her health had been fairly good. Her temperature on admission was 101° F., and her pulse varied from 100 to 120. On examination, her abdomen was found to be distended, owing to the presence in the lower part of a large and tense tumour, in the upper part of distended intestines. By vaginal examination, a tumour could also be found filling Douglas' pouch. The patient was kept under

observation for a few days, and attempts made to secure an evacuation of the bowels. As, however, there was no improvement, but rather a deterioration in her condition, Dr. Macan determined to open the abdomen. On July 31st he accordingly operated upon the patient—a proceeding at which he kindly invited me to assist. On opening the peritoneal cavity, it was found that the tumour was formed by a very large and very foetid collection of pus among the intestines. The collection extended upwards to slightly above the umbilicus, and downwards to the bladder, and the upper portion of Douglas' pouch. There were, as is usual, several loculi in which further and equally foetid collections of pus were found. With considerable difficulty all the contents of the abscess were evacuated, and the cavity was washed out and plugged from above with iodoform gauze. The abdominal wound was then closed save for a portion of the lower end, through which the gauze emerged. I may mention that towards the end of the operation the advisability of draining from the vagina was discussed, and with a view to making the necessary opening, Dr. Macan asked me to pass my fingers into the vagina in order to determine the direction in which an incision should be made. However, when I had done this, we found that the collection of pus had not extended to the bottom of Douglas's pouch, inasmuch as the latter was occupied by a swelling the size of an orange, anteposed to which was the uterus. The condition of the patient at this time was so bad that it was determined not to remove this mass, but to trust to drainage from above. This decision I consider to have been very wise, as the further manipulations which its removal would have entailed would quite possibly have been sufficient to turn the scale against the patient.

The condition of the patient after the operation was very critical. She suffered much from vomiting, her pulse was weak, and her temperature sub-normal. She, however, was able to take small amounts of liquid nourishment, and on the second day after the operation her bowels acted. On August 3rd, Dr. Macan went for his holidays, and the patient came under my care. She was then, to my mind, in an extremely bad condition, as a consequence of toxic absorption from the abscess. Her pulse was very feeble, and her temperature varied from subnormal to 101° F. Her skin was jaundiced, her eyes sunk in her head, and her mind wandering. Further, it was difficult to induce her to take nourishment. The wound had been dressed twice daily since the operation,

and the cavity douched out and plugged lightly with iodoform gauze. In spite of this, the smell of the discharge was still most offensive. As the solution with which the cavity was douched did not seem to produce any good effects—I believe that lysol had been used—I desired the nurse to inject instead a 25 per cent. solution of “sanitas” in warm water, and to wash out the cavity still more frequently than she had been doing. I had, however, very little hope of effecting a good result. The next day the patient was slightly better. The day after her condition was again improved, and the discharge was losing its extreme fœtor. This gradual improvement continued, until, by August 8th, the temperature had fallen to almost normal. At the same time, the abscess cavity was becoming notably smaller, and in a few days more it was possible to dispense with all plugging.

I may mention, incidentally, that in consequence of the infection of the abdominal wound by the contents of the abscess, all the sutures had cut out, and the entire wound, save for what was apparently a peritoneal floor, had reopened. As a result of the distended condition of the intestines, to which I will presently refer, this gaping became very marked, and must have measured as much as two inches across. Accordingly, as the condition of the patient was daily improving, I determined to bring together the edges with sutures. This I tried to do on August 19th, the sutures being passed subsequent to endermal injections of cocaine. In consequence, however, of the extreme thinness of the walls, and of the flaccidity of the skin, it was impossible to obtain a firm suture-hold of anything save the skin, and even then the sutures appeared merely to produce an inversion of the latter. However, the results of the re-suturing were not so bad as they appeared; the wound was immediately diminished by about half its width, and this was subsequently again further diminished by straps of adhesive plaster pulling over little rolls of cotton wool placed in the wound to keep the skin from inversion.

Unfortunately, the great improvement which had taken place in the patient's condition proved to be only temporary, and about September 1st she showed signs of returning to her former state. Her temperature again rose, reaching a height in the evening of 101° F., her appetite was lost, the abdomen became very tympanitic, and it was almost impossible to get the bowels to move. I then examined the abdominal wound very carefully, but could

find no sign of any accumulation of pus in its neighbourhood. The small sinus, which a few days previously had led to the former site of the abscess cavity, was almost completely closed. It appeared to be in every way healthy, and there was no evidence of any accumulation of pus around or below it. Accordingly, I made a vaginal and rectal examination, and was then easily able to determine the presence of a swelling completely filling Douglas' pouch, pressing upon the rectum, and obviously containing fluid. It was apparently larger than at the time of the operation.

As this swelling was obviously the cause of the patient's condition, I determined to remove it with as little delay as possible. Accordingly, on September 5th, five weeks after the first operation, with the assistance of Dr. Kennan, I opened the posterior vaginal fornix in the usual manner. On reaching Douglas' pouch I found that my finger came into contact with a well-defined tumour, adherent to the neighbouring structures, and containing fluid. The adhesions to the floor of Douglas' pouch could be easily broken down, but at the upper portion of the tumour they were very dense. Whilst breaking these down, a portion of the wall of the tumour was torn, and a quantity of very foetid pus escaped. With some little difficulty the tumour was separated from its upper attachments, and remained alone attached by what was apparently a pedicle connecting it with the right cornu of the uterus. There was no trace of any structure resembling the pelvic-infundibulo ligament. As there was a considerable amount of hæmorrhage from the broken down adhesions, and possibly from the remains of this ligament, I applied a clamp to the pedicle, divided the latter, and removed the tumour. Then, as there was no bleeding point to be seen, but a quantity of general oozing, I plugged the pelvis with gauze sponges wrung out of water at a temperature of about 115° F., taking care not to disturb the clamp. The following day I removed the sponges, a process which necessitated the administration of nitrous oxide gas. I had not intended to remove the clamp until the following day, but it came off in the process of re-plugging the pelvis, the reason for which was subsequently made very obvious. There was, however, no hæmorrhage. I re-plugged the pelvis each day through a glass speculum, inserted through the opening in the vaginal fornix. For the first few days it was necessary to administer an anæsthetic, as the patient could not bear the pain which the proceeding caused.

Each day the cavity became a little smaller, the patient's temperature gradually fell to, and then remained at, normal, and her condition materially improved. About the middle of September Dr. Macan returned, and I resigned her to his care. She continued to improve steadily from day to day, and on November 10th she left the hospital.

The history of the clamp, which fell off, is not uninteresting. It was given to the nurse to wash, and as soon as it was placed in warm water one blade fell off. It had apparently cracked half across at the lock during the application, and then completely across whilst it was *in situ*. The dried blood with which it was covered had, however, proved sufficient to hold it together. The clamp had been made in Germany. The moral is obvious.

There is one point which this case shows very clearly, and that is the amount of foetid pus which can be present in a patient without interfering with the temperature, when once she has become, so to speak, inoculated against such pus. In this case, after the patient had recovered from the first operation, her temperature fell to normal, and remained so for seventeen days. Yet all the while there was an accumulation of most foetid pus in the pelvis.

The action of sponges wrung out of very hot water in checking what was a considerable amount of hæmorrhage, was most satisfactory. Their temporary use had been suggested to me by Dr. Glenn in a previous case, where they had also succeeded admirably. In this case they were allowed to remain as a substitute for iodoform gauze, and were removed without difficulty on the following day.

The cause of the large abscess which Dr. Macan opened seemed to be very obscure at the time of his operation. There was a collection of pus among the intestines, apparently unconnected with any tangible source of infection. The subsequent discovery of the suppurating ovarian cyst will;

however, I think, explain its origin. To my mind, the case was originally one of an ovarian cyst, the pedicle of which became twisted. The contents of the cyst were then infected from the rectum, and this infection extended in turn through the walls of the cyst into the peritoneal cavity, setting up a localised peritonitis, and ultimately leading to the formation of a large abscess.

DR. MACAN remarked that the woman, whose history they had just heard, was the worst case he ever had in hospital. He determined on laparotomy on her admission, as if anything could be done it should be done quickly. The cause of her condition was found to be a foetid abscess. The fact that the temperature remained normal for seventeen days after it had become normal he considered to be noteworthy; it showed how there may be pus without a rise of temperature. He afterwards thought that he should have drained the abdomen through the vagina, but he found a firm mass in Douglas' pouch, and the patient was not young enough or well enough for a voyage of discovery. The forceps that broke was "made in Germany," but if you take too weak a forceps, say an intestinal one, to clamp an ovarian tube, you can break it, even if made in England.

DR. ALFRED SMITH said one could not estimate the character of the pus from its stench—pus collections in the neighbourhood of the rectum are notoriously ill-smelling. The relief of pain felt after opening an abscess, he thought, is due to the diminution of tension of the abscess sac. Emptying the first abscess relieved tension, pain ceased, and temperature fell. Then the second abscess ripened, became tense, and temperature rose. His favourite antiseptic wash was peroxide of hydrogen, with which he washes the sac until the fluid comes back free from air bubbles.

DR. PUREFOY, Master of the Rotunda Hospital, was of opinion that Dr. Jellett's paper offered several practical points for consideration—there was oozing of blood, which, in such cases, was not without danger. And he could not but think that both the operators, Dr. Jellett and Dr. Macan, lacked courage in not opening into Douglas' pouch from the vagina and emptying the pocket of pus, which afterwards gave so much trouble, necessitating a

second operation. Dr. Jellett's report was not consistent; the mass in Douglas' space is in one place referred to as a hard mass, and again spoken of as a collection of pus.

DR. MACAN rose to give a personal explanation. If a normal temperature is followed by a rise seventeen days after operation it shows that something must have happened.

DR. JELLETT, in reply, said the improvement in the patient after Dr. Macan's operation was only relative. Her temperature fell, her pain ceased for a time, but she could not be got to take food. The mass in Douglas' space had considerably increased between the operations—it was an increase in pus, not a fresh formation. The explanation of Dr. A. Smith that pain in such cases is due to tension of the sac is probably right.