

tumors. The symptoms of fibroids usually become more alarming toward the end of the reproductive period. The adenomatous goiter, in the great majority of cases, does not give much discomfort until the menopause. Then pressure and toxic symptoms arise. Small tumors in the breast have often existed from the age of 20 to the age of 40 without giving any symptoms, or without having been noticed at all; still, their long-standing existence usually is clear when their presence becomes obvious through growth or discomfort. Because of the aforementioned functional (physiologic) relationship which exists between thyroid, uterus and breast, we may be able to understand why growth or irritation in one of these organs may induce growth or irritation in another. For instance, when a small fibroid which has existed innocently for many years suddenly begins to grow, it may induce growth or irritation in the thyroid or breast (and vice versa).

CONCLUSIONS

1. In a series of 200 cases (100 fibroids and 100 goiters), fifty-three patients, or 26.5 per cent., had both goiter and fibroid. Five per cent. had breast tumors.

2. The age of incidence of these combinations was greatest after 35.

3. Since these three organs are not related anatomically or embryologically, the simultaneous occurrence of tumors in the thyroid, uterus and breast may be explained by their physiologic interrelationship.

4. The prophylactic treatment now advocated, of giving iodids for goiter, may likewise prove beneficial in the prevention of fibroid.

5. Perhaps certain goiters can be reduced in size or even cured by the removal of a fibroid (as suggested by Ullman).

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Clinical Notes, Suggestions, and New Instruments

REPORT OF A CASE OF FULL TERM ABDOMINAL PREGNANCY

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A colored woman, aged 33, married, was admitted to Grady Hospital, Dec. 3, 1920, complaining of weakness and pain in the right lower abdomen. She had always been in good health and gave no history of serious illness, operations or venereal disease. Her menses had been regular. She had had three full term, normal pregnancies and labors with normal puerperia, the last one occurring in 1917. There had been no miscarriages.

The menstrual periods were regular and normal during the summer and fall of 1920, and the October period began at the regular time but was more profuse than usual, and lasted two weeks. From this time on, the periods remained absent. During the latter part of October and during part of November, she was nursing a sick relative and thought that the strain of lifting the patient caused pain in the right lower abdomen. She gave no history of a sudden sharp pain or fainting attack. The pain in the right lower abdomen continued throughout November, and was associated with considerable weakness.

She came to the hospital early in December, 1920, complaining of pain in the right lower abdomen, and weakness. She was repeatedly questioned and examined during her stay

of one week. Examination disclosed a mass in the middle lower abdomen of the size, shape and consistency of a normal four months' pregnancy; the lower abdomen seemed to be more than normally tender, especially in the right lower quadrant. The skin showed a yellowish pallor. Vaginal examination revealed a moderately firm cervix in normal position and apparently continuous with the mass described, although the tenderness of the abdomen prevented satisfactory palpation. The fornices were soft, and no mass was palpable on either side, although there was more tenderness on the right. Had the patient been examined under anesthesia with, perhaps, a puncture and aspiration of the cul-de-sac to endeavor to demonstrate the presence of free blood in the pelvis, the true condition might have been recognized; but as there seemed to be no apparent cause for her complaint, she was discharged and not seen again until readmission to the hospital, June 3, 1921.

The pregnancy had apparently progressed normally except for more pain than she had ever experienced with her previous gestations. On examination, the skin showed a yellowish, anemic tint with some pallor of the mucous membranes. The heart and lungs were normal. The blood pressure registered 135 systolic and 90 diastolic. The size and contour of the abdomen were quite typical of a full term intra-uterine pregnancy, except perhaps for a somewhat more abrupt rise above the pubes than normal. A moderate degree of hydramnios was suspected on account of a fairly definite fluid wave and the shiny appearance of the skin. There was more than normal tenderness to palpation. The fetal parts were distinctly palpable, but not to a greater degree than in many thin walled multiparous uteri. The position of the fetus was readily recognized as left sacro-anterior, and the fetal heart sounds were distinctly heard to the left and above the umbilicus. The inlet measurements were normal. Rectal examination revealed no dilatation of the cervix and, although the patient complained of irregular pains, no definite contractions were noted. However, as labor was likely to begin at any time, the patient was kept in the ward under observation. After several days, an attempt was made to induce labor with castor oil and quinin, but without success.

June 8, the patient ceased to feel movements, and repeated examinations failed to reveal fetal heart sounds or movements. It was deemed best not to interfere but to let labor come on naturally, if possible, and the patient was permitted to go home for a few days.

She returned to the hospital, June 23, and stated that bleeding had commenced, June 21, and still continued. She had also been feeling worse during the last week on account of increased backache, feeling of weight in the pelvis, and a foul taste in the mouth. During the next two days, an afternoon rise of temperature to 100 F. was noted. Examination revealed the same physical findings as before, but the cervix seemed slightly more open, although only moderately softened.

It was decided to induce labor on account of the delay in expelling the dead fetus and the evidence of beginning infection, as there seemed to be no other cause for the rise in temperature. June 25, 3 p. m., two large rubber catheters were passed through the cervix. It was noted that the catheters seemed to encounter a firm obstruction after passing in about 10 cm., but this was thought to be, possibly, the placental implantation. On the 26th, at 8:30 p. m., the catheters were removed, no definite pains having resulted. However, the cervix was now dilated sufficiently to admit one finger. On the 27th, at noon, a No. 4 Voorhees bag was introduced through the cervix. The canal seemed to lead off to the left. The membranes could not be reached. On the 28th, at 5 p. m., the bag was removed, as no definite pains had resulted. Examination after removal of the bag revealed that the cervix was dilated about three fingers' breadth and, on further exploration, was found to lead into a cavity about 10 cm. in depth, manifestly a nonpregnant uterus.

The probable diagnosis, therefore, was an extra-uterine pregnancy which must have ruptured at an early stage and retained sufficient attachment to develop to full term as an abdominal pregnancy. It was also possible, but less likely,

that the patient had a double uterus with pregnancy in one side.

The patient was visibly weaker and beginning to appear septic. The temperature had reached 101 F., the pulse was more rapid, from 110 to 120, and the abdomen becoming more tender. An area of tympany in the umbilical region was interpreted as due to adherent intestines in this region. The white blood count was 18,600, with polymorphonuclear cells 81 per cent. and hemoglobin 55 per cent. The urine showed heavy albumin, with many granular and hyaline casts. The contents of the sac were evidently becoming infected, and operation was urgently indicated.

June 29, under gas-oxygen anesthesia, a vaginal examination revealed that the uterus was only slightly enlarged, about the size of a six weeks' pregnancy, and displaced to the left, lying almost parallel to Poupart's ligament. At the beginning of the operation, hypodermic stimulation with caffeine and intravenous injection of 500 c.c. of physiologic sodium chlorid solution with epinephrin were given. When a midline incision between the pubes and umbilicus was made, the wall of the sac was firmly adherent to the parietal peritoneum and accidentally opened, releasing a large amount of gas and brownish fluid of foul colon odor. An 8 pound (3.6 kg.) macerated female infant was removed and, after complete evacuation of the fluid, the sac was seen to be completely isolated from the abdominal cavity. The placental end of the cord led up toward the liver, from which it could not be traced. The placenta seemed to be in the pelvis, but, when I attempted to locate it more definitely, a sharp hemorrhage occurred in the pelvis, which fortunately was controlled by the pressure of a hot pack as there was no definite blood supply to be clamped off. The pelvic organs were completely covered over by the sac wall, which had a roughened, somewhat necrotic appearance. A piece of dry gauze was placed over the site of the hemorrhage and three large cigaret drains were placed to drain the sac, through the lower end of the incision, which was closed to this point. The patient's condition remained satisfactory throughout the operation, and she reacted quickly.

July 4, the gauze was removed and, on the 11th, the drains were removed. On the 20th, the wound had broken down and the placenta appeared in the depth of the cavity. July 27, and, again, August 3, two large pieces of necrotic placenta were successively extruded and easily lifted out, leaving the wound quite clean and granulating rapidly. There was no fever after August 2. The patient was allowed out of bed, August 13, and discharged from the hospital on the 21st, with the wound practically closed.

COMMENT

Dr. Beck¹ reports a case of abdominal pregnancy, and analyzes 262 cases compiled from the literature from 1809 to 1919. He urges that every case be reported and states, in his conclusions, that the interests of the child should be considered; that interference at the thirty-eighth week of gestation offers the best chance of saving the child and is associated with less operative risk than at any other time; that preliminary preparation for hemorrhage should precede the operation; that it is best to remove the placenta if it is possible first to ligate its blood supply; otherwise it should be left in and the abdomen closed without drainage, as it will ultimately be absorbed, although occasionally it may become infected from the intestines and subsequently require drainage; and that marsupialization is indicated in those cases in which the blood supply of the placenta cannot be controlled, or hemorrhage requires a tampon, or infection necessitates drainage.

It was unfortunate that the diagnosis of abdominal pregnancy was not suspected in this case, in the early stages of the pregnancy or at the termination of the pregnancy before the fetus died, as an operation undertaken a few days earlier would have saved the child as well as the mother. However, the absence of a history suggesting ectopic pregnancy, and the omission of an examination under anesthesia to clear up the doubtful physical findings, delayed the true diagnosis until efforts were made to induce labor. The obscure ana-

tomic relations of the placenta and its blood supply, the hemorrhage set up by manipulations, and the presence of infection made it necessary to drain, and to depend on the patient's own resistive powers to absorb or extrude the placenta, control the infection, and restore her to health.

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LIGATION OF FEMORAL ARTERY IN MIDDLE THIGH

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J. K., a man, aged 25, laborer, April 4, 1921, while employed on the construction of an ore dock, was struck by an iron rod about 20 feet long and 1½ inches in diameter, which fell from the work above him. It came down endwise, struck him in the middle of the left thigh, and passed down through the popliteal space and out of the outer side of the leg about the middle and on to the ground, fracturing the fibula in addition to inflicting severe lacerations of the soft parts. No serious hemorrhage occurred at the time, nor was there more than slight primary shock.

The man was taken at once to the hospital, and the wound track was cleared of débris. The femoral artery could be felt pulsating in the upper wound, the rod having passed in front and to the outer side of the vessel and behind the popliteal artery, the leg being slightly bent when struck. A dressing was applied, and the patient was put to bed. All went well for six days, when suddenly, without warning, the wound in the thigh began to bleed copiously. Being in the hospital and near at hand, I was able to check the bleeding and apply a ligature to the bleeding point. The case then pursued a normal course for six days more, when, being in the vicinity of the ward, I heard the patient cry out and, hastening to him, found the wound bleeding again most seriously. Hastily removing the dressing and placing a thumb in the wound over the artery, I was able to control the bleeding until instruments could be procured. I then clamped the femoral artery in the upper and lower angles of the wound, and had the patient removed to the operating room. The femoral artery had been injured, erosion had taken place, and the wall had finally given away so that there was an opening 0.5 by 1 cm. in the side of the vessel. Had not help been instantly at hand, a fatal hemorrhage must have occurred. As it was, nearly a pint of blood escaped. Nothing could be done but to ligate the artery above and below the opening and await results, with the expectation, of course, that it would be necessary to amputate the leg.

The entire leg lived, however, and by keeping it encased in cotton to keep it warm, and slightly elevated to facilitate the return venous flow, we found that there was sufficient collateral circulation to sustain its vitality. The wounds healed slowly; the one in the thigh healed in eight months, and the wound of exit in the leg remained as a slow healing ulcer for nearly a year. The patient walked on the leg in about three months. There was no swelling or edema of the leg of any consequence at any time. Thirteen months after the injury the wounds had entirely healed, and there is very little difference in the size of the legs, the injured one being a little smaller.

No pulsation can be felt anywhere in the injured leg. It can be felt at the usual locations in the right. When the blood pressure apparatus is applied to the left leg, with the cuff above the knee, the mercury oscillates at 110 and 70; no sound is heard over the popliteal space or anywhere below. The cuff applied below the knee gives the same effect. Collateral circulation is well established, and the leg approaches nearly normal function.

The femoral vein was apparently not injured, and this is no doubt a factor in saving the leg by favoring the return circulation. The first hemorrhage was evidently due to the giving way of a branch of the femoral artery, since the bleeding point was easily caught and controlled by ligature. The second hemorrhage came through an opening so large in the softened wall of the artery that closure was not to be thought of.

1. Beck, A. C.: Treatment of Extra-Uterine Pregnancy After Fifth Month, J. A. M. A. 73: 962 (Sept. 27) 1919.