

An unusual case of haemato-salpinx (recurrent haemato-salpinx) / by R. Lawford Knaggs ; communicated by A.L. Galabin.

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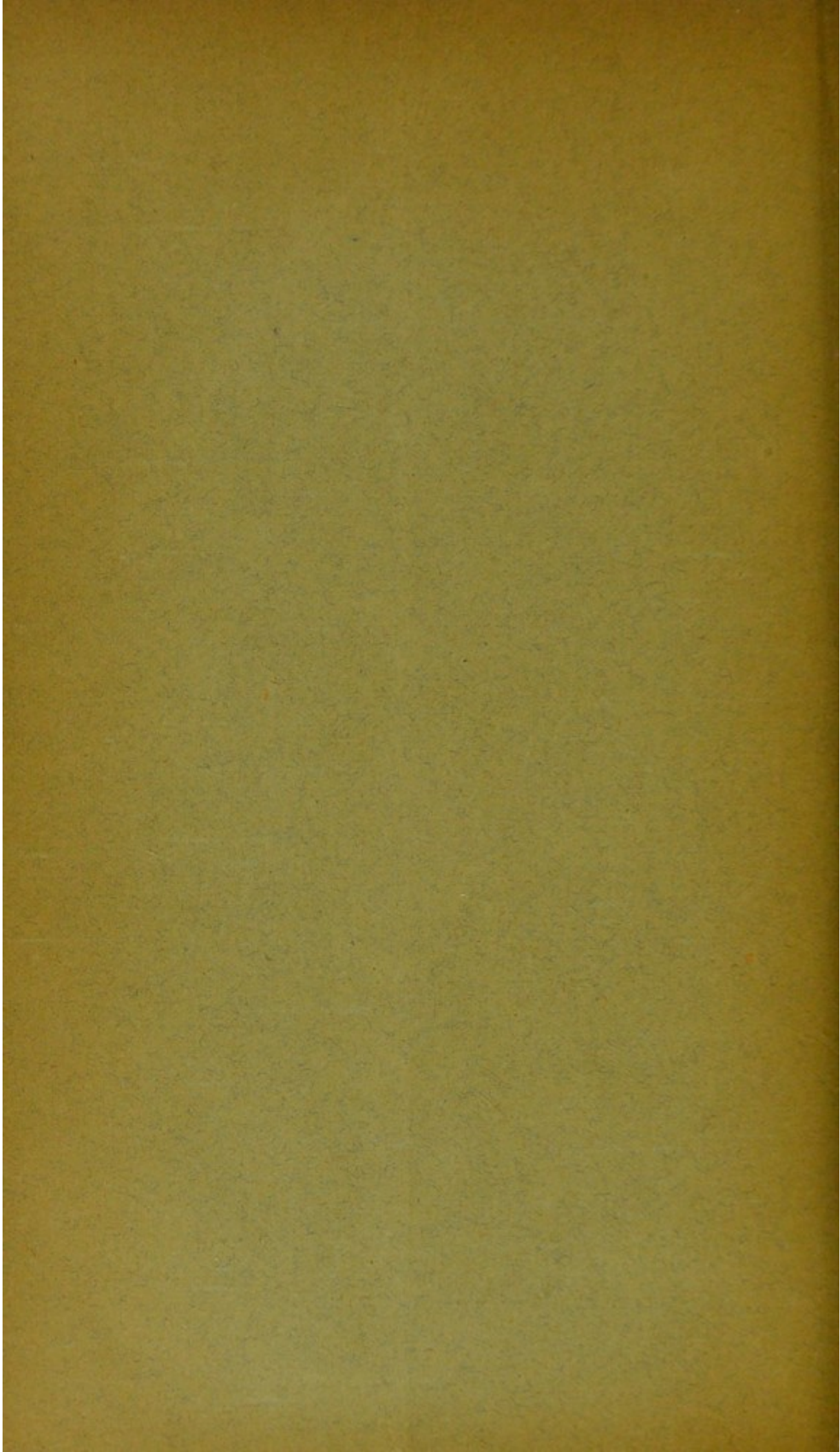
Case of Hemato. Salpinx

by

R. Sanford Knapp



1893



AN UNUSUAL CASE
OF
HÆMATO-SALPINX
(RECURRENT HÆMATO-SALPINX).

BY
R. LAWFORD KNAGGS, M.D.CANTAB.

(COMMUNICATED BY DR. A. L. GALABIN.)

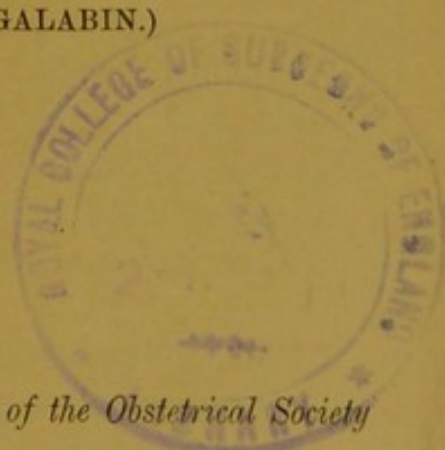
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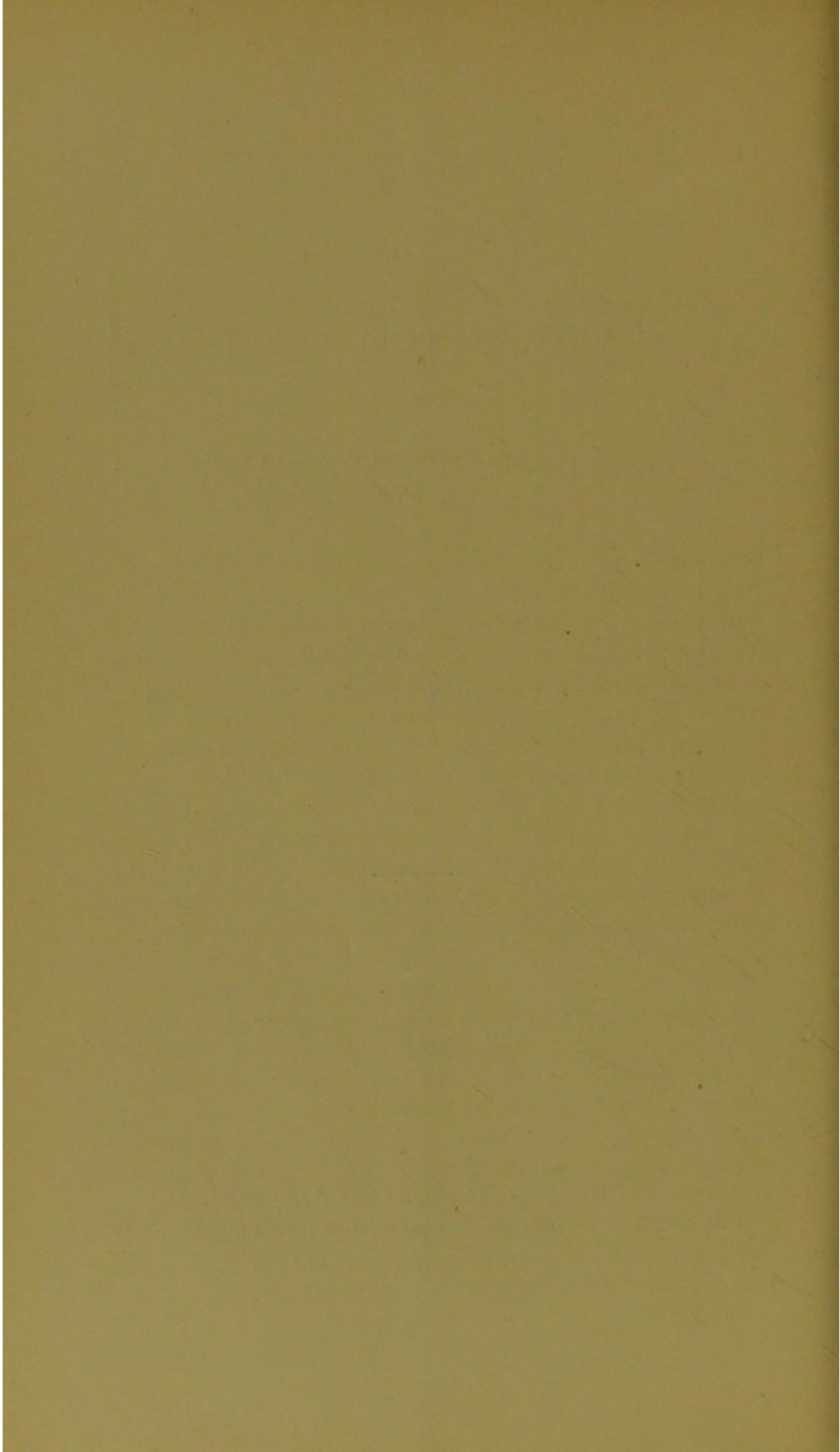
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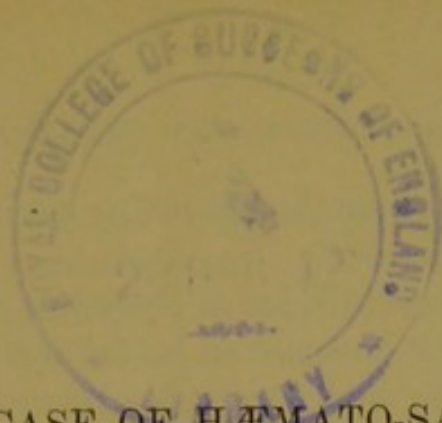
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AN UNUSUAL CASE OF HÆMATO-SALPINX
(RECURRENT HÆMATO-SALPINX).

By. R. LAWFORD KNAGGS, M.D. Cantab.

(Communicated by Dr. A. L. GALABIN.)

(Received October 3rd, 1892.)

THE following case is so unusual that I venture to place it upon record.

Mrs. — æt. 44, began to menstruate at eleven. She was always regular, every fourth week, till August, 1891. The catamenia lasted five days, till two years ago when they began to average five to seven days, and the quantity lost to be variable. She always felt better when the loss was greatest.

Fifteen years ago she contracted gonorrhœa (probably) and syphilis (certainly) from her husband. This was followed by a rash. She has had four children—twins, which died the day after birth, and two healthy girls—the last being born six months before the venereal condition appeared.

Mrs. — came under observation on October 17th, 1891. Two years before in November, half a day after the natural menstrual discharge had ceased, she went out to the post. She got home with difficulty in consequence of a sudden profuse vaginal discharge, which soaked into her boots. It was very offensive, deeper in colour than menstrual blood, and contained black lumps. This bloody discharge lasted twenty-four hours, and was succeeded by an offensive greenish-yellow discharge, so profuse that she laid on a couch and applied a sheet instead of a diaper. At this time she had much pain chiefly on the left side near the

groin, but during the preceding period there had been no unusual discomfort.

The purulent discharge ceased in a fortnight, and afterwards she felt better than before the trouble began, though previously she had hardly been conscious of not being well.

The next period was quite natural, and with the exception of "burning feelings in the left side low down" everything went on as usual till August, 1891, when a similar sequence of events occurred.

On Bank holiday the period ceased in the afternoon, and the next morning on getting out of bed the dark offensive discharge came on suddenly without a moment's warning. It contained black soft lumps an inch or two long. The dark bloody discharge lasted for two days, and was followed by the same greenish yellow discharge which lasted nearly a fortnight. There had been no antecedent discomfort beyond a slight feeling of fulness and a desire to micturate. She again felt the better for the discharge. Up to August the catamenia had been regular. The next period was missed, and on October 7th (a second period having been missed) on getting out of bed to get up, the offensive dark bloody discharge, again containing soft black lumps, once more occurred. Quite a pint came away with a rush causing "a feeling as of bearing down in labour." The dark discharge persisted till the 10th, and after passing through a purulent stage soon ceased. On the 10th she caught cold from having to wait at the railway station, and for the next few days she felt shivery, and had much pain round her hip bones, and kept her bed. She gradually improved and was up, when she sent for me on October 17th.

When examined, the abdomen was found free from tenderness and capable of palpation. There was a sense of resistance deep in the left iliac region and firm pressure here was uncomfortable. On vaginal examination, the uterus was about the normal size and could easily be grasped bimanually. It was pressed to the right side of the pelvis by a swelling in the left broad ligament. The uterus was

barely moveable, and the sulcus between it and the tumour could be felt nearly its whole length. To the left of the uterus was a tense, rounded, swelling, as big as a foetal head reaching from the uterus to the side of the pelvis. The fingers could meet bimanually in front of it, and the examining finger could reach well up behind it. The swelling was not moveable, and felt as if it contained fluid. It was evidently situated in the left broad ligament.

The fixation of the uterus and tumour were due to anatomical conditions and not to cellulitis. The right appendage could not clearly be felt.

On the 23rd, she was seen by Mr. Mayo Robson, and a diagnosis of hæmato-salpinx was agreed to.

The same day she had an attack of diarrhœa which lasted for two or three days. It was probably due to cold, and it may be at once stated that it had no direct connection with what subsequently transpired. Whilst it lasted, however, some discharge of a dark offensive character came away by the vagina in small quantities in the night time and was noticed on the sheets. The total amount was estimated by the patient at "perhaps a teacupful." After the diarrhœa she quickly recovered her normal health, and on November 7th I made another vaginal examination. The uterus was still on the right side, more moveable, but the tumour had completely disappeared. In its situation some thickening could be felt bimanually but very little detail could be made out. There was slight tenderness. She entered a nursing home but operation had to be postponed in consequence of an irregular and unexpected menstrual discharge, and another attack of diarrhœa produced by a dose of magnesia. The tumour did not reappear before operation, which took place on November 20th.

When the abdomen was opened a swelling as big as a small peach was found at the pelvic end of the left broad ligament. It was immovable, and firmly fixed to the brim and side of the pelvis. The ovary formed its posterior and lower surface. Its detachment was effected by working from the under surface of the ovary along the pelvic wall,

and as this was being done the ovary seemed to tear and a rough surface was exposed to the finger. This rough surface was the inside of a cavity which was partly bounded by the side of the pelvis. A portion of the interior of the cavity was left *in situ* where the pelvis entered into its formation. The whole of the swelling, however, was detached, and when drawn up into the wound proved to be chiefly composed of an ovary and a thickened and dilated ampulla of the Fallopian tube. The diseased parts were removed three quarters of an inch from the uterus, and the ligatured pedicle returned. The other ovary was found after some difficulty firmly adherent to the brim of the pelvis close to the right sacro-iliac synchondrosis. There was no swelling of the right Fallopian tube and as the symptoms had been limited to the left broad ligament it was decided not to interfere with it. There were some thread-like bands of adhesion about the uterus in Douglas's pouch which were ruptured during the examination.

There was very little bleeding and the abdomen was closed in the ordinary way.

The subsequent course was satisfactory and the patient made a good recovery, the temperature never reaching 100°.

The specimen is composed of the left ovary and the much thickened and slightly dilated Fallopian tube. There is a good deal of false membrane upon the anterior and posterior surfaces (of the broad ligament).

The abdominal extremity of the tube seems continuous by a part of its circumference with the tissue covering the ovary. Where the abdominal ostium and the ovary meet there is a cavity as large as a Barcelona nut, which has been formed in part by the extremity of the tube, in part by the ovary, and the adventitious tissue connected with it, and in part by the parietal peritoneum near the brim of the pelvis. That part of the cavity corresponding to the parietal peritoneum was left behind upon the side of the pelvis, and after the separation of the appendage, its rough interior could be easily detected *in situ*. In the

specimen the opening in the cavity is due to the absence of this portion of its wall.

Its interior is very irregular and rough, and the lumen of the Fallopian tube is directly continuous with it. Where the pedicle was tied—three quarters of an inch from the uterus—the tube was only slightly thickened.

From the proximal extremity of the specimen muco-pus could be expressed, and a similar secretion covered the interior of the cavity, but there was no noticeable collection of fluid, and no sign of blood.

Now it is open to question whether this case should be regarded as a variety of hæmato-salpinx, but clinically it appears to have a closer connection with that disease than with any other condition. The pathology of hæmato-salpinx does not at present seem to be thoroughly understood. Bland Sutton is of opinion that nearly all specimens supposed to be examples of it are cases of tubal gestation, and he thinks that the term hæmato-salpinx should be “exclusively reserved for Fallopian tubes in which the abdominal ostium is closed, and the dilated portions occupied by clot in which no evidence of pregnancy, such as an embryo, apoplectic ovum, or chorionic villi, is detected.” ‘Surgical Diseases of Ovaries and Fallopian Tubes,’ p. 263.

With reference to the possibility of tubal pregnancy in the present instance, it should, perhaps, be stated that the patient had been separated from her husband fourteen or fifteen years; and as the abdominal ostium, though opening into an abscess cavity may be considered as closed for all practical purposes, the pathological appearances, as well as the peculiar history of three distinct septic floodings, would seem to eliminate that condition completely.

Was the tumour, which was discovered, due to the distension of the Fallopian tube and the abscess cavity that was continuous with it?

In case any doubt may possibly be entertained upon this point, it may be stated: (1) That the only unusual condition found on the left side at the operation was the

diseased state of the appendage, which has been described ; and (2) that the floodings, which were becoming more frequent and appeared to have a close association with the catamenial discharges, or with periods at which they were due, have not occurred since the operation, although the menses have made one irregular appearance.

It is astonishing that so large a tumour could have been formed by the distension of such a thickened tube, and it is possible that the abscess cavity which formed a prolongation of the tube may have taken a large share in its production.

That the condition was, in the main, tubal is certain. The clinical and pathological facts all point to it, and they can be supported by an explanation, which, though it presents some points of difficulty, is fairly simple.

Before attempting this, several facts in the history of the case are worthy of notice.

1. The large quantity of the hæmorrhagic discharge, the unexpected suddenness of its onset, and its decomposing character, show that a collection of blood had existed for some little time before escaping. The profuse discharge which followed, and which was at first blood stained and subsequently purulent, was no doubt secreted by the cavity from which the blood came, and the diminution of the discharge probably corresponded with the shrinking of the cavity. A further deduction may be made, that, if the purulent discharge was secreted by the walls of the cavity, the blood was poured out from the same surface. And this is interesting, for the source of the menstrual blood is said to be the mucous membrane of the uterus ; but here the mucous membrane of the Fallopian tube was diseased.

2. It is obvious that the cavity communicated with the generative passages, and the examination of the parts removed showed that it was a natural communication.

3. On the first and second occasions on which the sudden discharge took place, the menstrual period had just been completed, and presumably accounted for the

presence of the blood collection. And on the third and last occasion, though the period had been missed, the incident occurred shortly after the menses should, under ordinary circumstances, have ceased.

4. When the swelling was subsequently found on the left side it was evidently the cause of the discomfort that had begun seven days before, and which dated from a serious chill that the patient had caught by waiting at a railway station on a cold wet day. The third flooding had then taken place only three days before, and the after discharge had not ceased. On the previous occasions the purulent discharge lasted a fortnight, but this time it soon stopped, notwithstanding she had caught cold.

Now, assuming that the tumour was the distended and dilated tube and abscess cavity, the foregoing facts may be explained in this way.

During the catamenial period a secretion of blood took place into the tube, and its escape was prevented from blocking of the uterine opening by the swollen mucous membrane. As the abdominal ostium was also closed, a considerable collection took place within a cavity already septic. Decomposition of the blood ensued, and with the decline of menstruation, and diminishing of congestion, the block at the uterine end of the tube was removed, and the contents escaped. Temporary plugging of the opening by one of the clots would account for the sudden copious flow instead of a gradual relief through a slowly enlarging channel.

From the unhealthy lining of the septic tube and abscess cavity, a purulent discharge, at first more or less stained with blood, naturally resulted, and it became less as the cavity contracted, and the secreting surface diminished. On October 10th the cavity had emptied itself, and the subsequent discharge was in progress when the patient caught a serious cold. The parts again became congested, the block at the uterine end of the tube recurred, increased discharge—possibly with blood—took place into the cavity, and a tumour formed, which gave rise to much discomfort

from its tension. This was the condition that was found when the patient was first examined. As the congestion subsided, the block was again removed and the contents trickled away (this time gradually, possibly because of the absence of clots), and as the tension was relieved, the uncomfortable symptoms vanished, and the diseased appendage gradually resumed the appearance that was found at the operation.

Note.—Dr. Thomas Ashby, of Baltimore, has described a case having much the resemblance to the foregoing ('International Clinics,' vol. iii, p. 234). The patient, a woman of thirty-seven, suffered from intermittent and irregular hæmorrhage, which occasionally issued from the vagina on the least exercise, in sufficient quantity to deluge her clothing. A sausage-shaped tumour, not unlike a pus tube, had been observed within the pelvis, but was not always present. When the tubes were removed, the abdominal ostia were found closed, the walls hypertrophied, the mucous lining thickened and hyperæmic, and their cavities enlarged and containing dark grumous blood, but no clots.



