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BY

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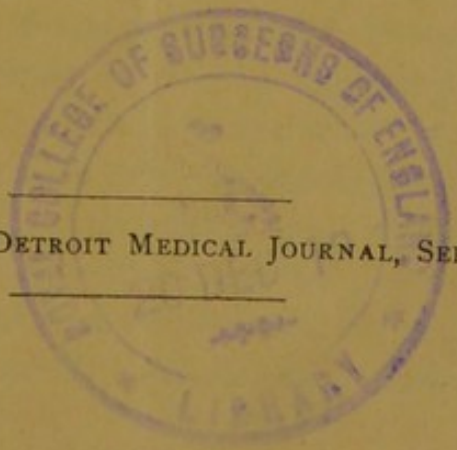

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Three Cases of Pelvic Abscess.

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The following cases illustrate the principles of treatment of abscesses in the tissues immediately surrounding the womb.

I. N., a girl, 16 years of age, came under my charge last September in Harper Hospital. She had always borne a good character, and her trouble had been referred to taking cold at the menstrual period. She had been ill for more than a year, with pelvic pain, disordered menstruation and spinal tenderness. She had constant inclination to pass water, and pain during micturition. A purulent discharge from the vagina, at times very profuse, seemed to indicate the presence of an abscess. Digital examination revealed a swelling situated in the anterior aspect of the vagina. When a catheter was passed into the bladder, the finger in the vagina could detect a great thickening of the vesico-vaginal septum—no orifice could be discovered through which pus discharged from the tumor into the vagina, though an exploring needle thrust into the swelling, showed the presence of pus.

I cut into the abscess, let out the matter, and put in a drainage tube of India rubber. This occurred on September 10th, 1876. The tube slipped out at the end of ten days, and the abscess seemed to be nearly healed. The pus collected again and required re-evacuation. This was done on October 27th, and a new drainage tube, prepared by Dr. Longyear, the House Surgeon of Harper Hospital, so as to be self-retaining,

was inserted. On June 22d, 1877, she was discharged, cured of her trouble.

Mrs. R., aged 47 years, and the mother of three children, entered Harper Hospital in May, 1877. She had suffered for nearly two years from an abscess in the pelvic tissue between the womb and rectum. In October, 1876, her menstruation had taken place for the last time. She was complaining bitterly of bearing down pain, of irritability of the bladder, difficulty in evacuating the bowels, and general pelvic distress. The abscess had, at one time, discharged through the vagina, and there was, when I examined her on May 30th, a sinus still existing, through which a small quantity of pus was discharged. This sinus ran anterior and immediately adjacent to the rectal wall. A probe in the sinus and the finger passed high up into the rectum seemed to be separated from each other by mucous membrane only. Anterior to the sinus there was a large tumor, continuous with the posterior wall of the uterus.

An exploring needle having shown the existence of pus, I plunged a bistoury into the swelling between the orifice of the sinus and the uterine wall, the patient lying upon her side and face and Dr. Boothey holding a Sims' speculum in the vagina. I was horrified on withdrawing the knife to notice, bubbling from the wound, a large quantity of offensive gas. The immediate inference was that the knife had entered the bowel. This proved, however, not to be the case. The wound was entered with a catheter, and a large quantity of offensive pus discharged. The gas had evidently penetrated into the abscess through the old sinus, which communicated with it, and permitted a slight escape of pus. It had then, as the woman lay on her side, floated on the top of the fluid, and had first escaped after the incision. The patient was immediately relieved of her bad symptoms, and began rapidly to recover and gain in flesh.

Drainage tubes were inserted and retained until the abscess had healed from the bottom. Menstruation returned in the latter end of June, and she left the hospital on June 28th, to remain, I trust, permanently well of her trouble.

In both of these cases chills and hectic fever were present

until the abscesses had been opened and a free channel secured for discharge, and then disappeared. These cases illustrate the advantage of drainage tubes in the treatment of these troublesome and tedious varieties of abscess. A simple incision for the purpose of evacuating the contained pus, will rarely cure a large pelvic abscess. The organs are so movable and the tissue so lax that it is difficult to make an incision so large or so dependent as to secure complete and constant drainage. This may be done, however, by tubes of India rubber, secured in place, and left until healing has been nearly accomplished.

The third case was one of different character. Mrs. G., a German woman, thirty years of age, had been married several years but had no children. About the middle of January, 1877, she was seized during her menstrual period with severe cramps in the lower part of the abdomen. They passed away in a few hours, but recurred during the next night. For six weeks thereafter she was continually seized with periodical attacks of pelvic pain, which occasionally would extend the whole length of the right lower extremity. She lost appetite and courage, and after seeking relief in vain from several physicians, finally placed herself in my hands.

After keeping her under observation for a few days, and satisfying myself by repeated trials with quinine, arsenic and salicine that the periodical pains were not due to malarial poisoning, I made a thorough examination of her pelvic organs. There was no abdominal tenderness on external pressure, but external pressure combined with digital examination revealed a small, hard tumor on the right side of the womb, apparently not more than two inches in diameter, which was painful when grasped between the two hands. The uterus was freely movable, the tumor moving with it. The uterine sound revealed normal dimensions of uterine canal. I called Dr. Jenks in consultation. He differed with me in diagnosis, as he was disposed to regard it as a circumscribed abscess forming in the peritoneal sac, while I looked upon it as an inflammation of the cellular tissue between the folds of the right broad ligament. Luckily no opportunity was given to verify diagnosis by an ab-

duction. Anodyne suppositories and medicines were prescribed to relieve pain, while the patient could be kept under observation. Nothing, however, seemed to give relief from the ever recurring cramps and pains. In the morning she would be quite easy, but about 4 P. M., the distress would begin, and not cease during the entire night.

Finally, on May 1st, the swelling growing neither larger nor smaller nor softer, assisted by Dr. A. M. Hawes, I put the patient under ether, and placed her on the left side and face in order to use a Sims' speculum. I fixed the womb with a tenaculum, and, guided by the fore finger of the left hand, thrust one of the smallest sized aspirator needles into the tumor. A drop of pus followed, but only a drop, and the aspirator was powerless to draw more. On the withdrawal of the needle, I discovered that the swelling had suddenly collapsed, the hard, circumscribed tumor having given place to a soft, illy defined tumefaction. I thrust a larger needle through the same puncture and succeeded in getting about a tablespoonful of pus. All operative procedures were then discontinued. The patient was put to bed, and for the next two weeks suffered severely from an intense inflammation of the bowels. Recovering from this, she found herself free from her old pain, and is now well. This case was remarkable from the peculiar persistence of symptoms without any evidences of a tendency in the abscess to grow or to discharge, from the injury following the puncture of the swelling by the smallest sized needle in my case, and by eventual recovery after a renewed inflammation had excited fears of a re-accumulation of pus.

I am inclined to account for the symptoms following the puncture by the assumption that the abscess was between the folds of the broad ligament, and that the needle, before entering it, passed through a pouch of the peritoneum. The discharge of pus through the puncture would necessarily cause a peritonitis of a more or less severe grade. It might also be explained on Dr. Jenks' theory that the abscess occupied a pouch of the peritoneum, and that the needle was inadvertently thrust too far,

passing through the abscess and making a passage into the, as yet, unaffected perineal cavity beyond.

I do not think, however, that this theory is correct, for I use the aspirator, in such cases, in such a way that the fluid is drawn into the needle the moment it enters the cavity in which it is contained, and I cease to advance it when that object is attained.