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Contributors

Savage, Thomas, 1839-1906.
Doran, Alban H. G. 1849-1927
Royal College of Surgeons of England

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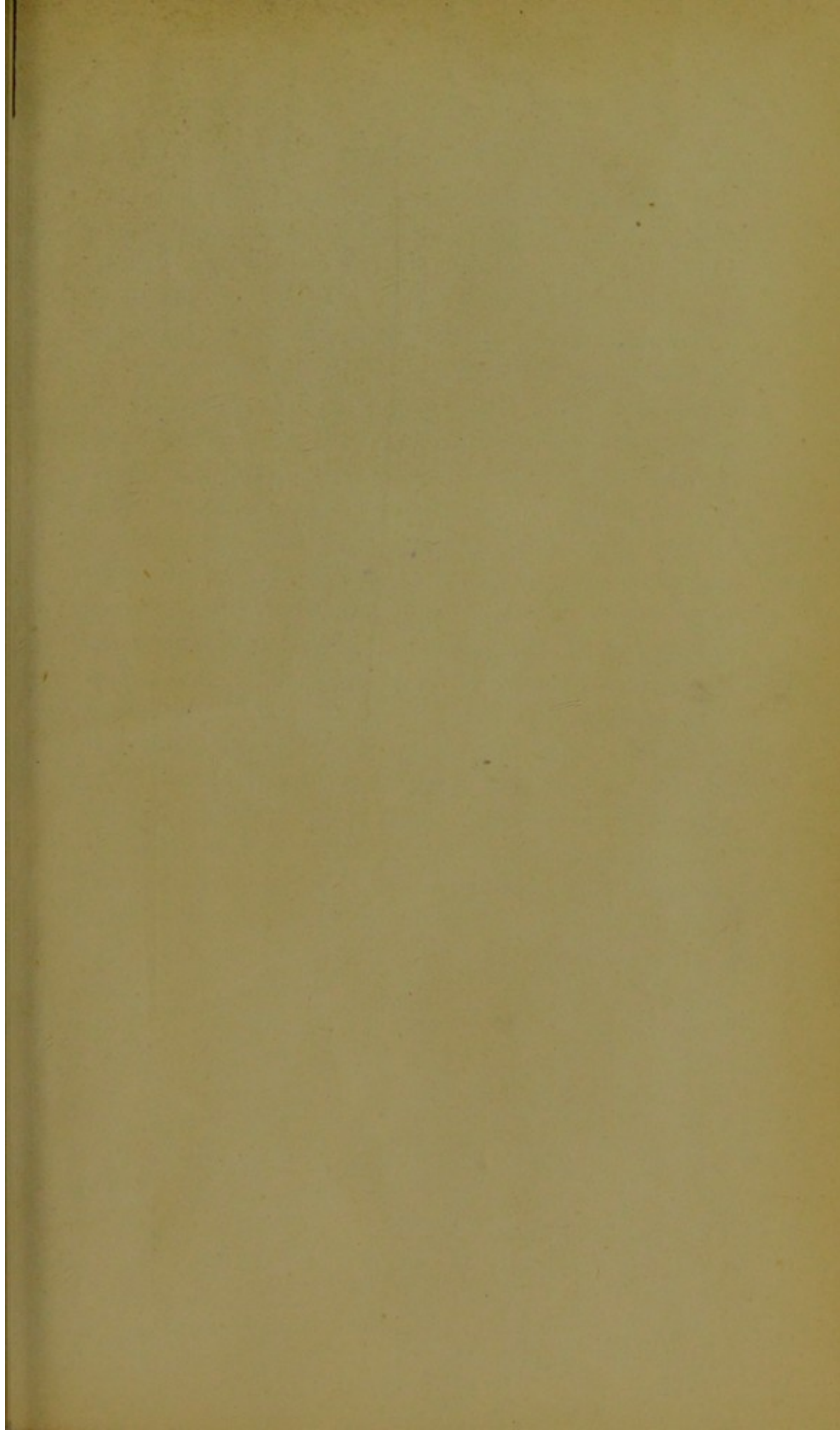
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 DISEASES OF THE FALLOPIAN TUBES.

BY THOMAS SAVAGE, M.D., M.R.C.P. LOND., F.R.C.S. ENG.,

SENIOR SURGEON TO THE BIRMINGHAM HOSPITAL FOR WOMEN, AND
 CONSULTING OBSTETRIC SURGEON TO THE KIDDERMINSTER INFIRMARY.

THERE is no doubt but that the diseases of the Fallopian tubes have received but very little notice from the practising physician or surgeon. They have been long recognised in the *post mortem* room, and Astruc, more than a hundred years ago, gives almost as much information on the subject as is to be found in books of recent publication. Very little attention has been given to their diagnosis, and it has been reserved for the present time to be the era of the successful treatment of these disorders. Commencing with the treatment of ovarian tumours by abdominal section, extensions of this method have gradually progressed onwards to attack other disorders in the abdominal cavity, of which those of the Fallopian tubes form one of the most important.

The diseases to which I shall refer are the well-known distensions of the tubes, viz., hydrosalpinx, pyosalpinx, and hæmatosalpinx. Of the last named I at present know but little.

Not so many years ago, in the majority of cases of women's diseases, the physician's energy was mainly concentrated on the periodical application of nitrate of silver to the os uteri, for so-called "ulceration,"—a cure not always resulting. We were in time led to see that it was necessary to go into the cervix, or even into the body of the uterus to apply local medication, which plan has been found in so many cases to be beneficial. Tilt and others directed our minds to the ovaries and ovarian influence; and we have been making gradual progress

onwards until at the present time we are prepared, in investigating a given case, to seek for the true cause of the ailment, and to trace out in due order the natural sequence of events.

The uterine cavity, although surrounded by a large amount of muscular tissue, which is there to serve a special function, ought to be looked upon as a continuation of Müller's duct, from which it has been developed. The Fallopian tube is likewise developed from the same foetal structure, being in reality only the upper portion of Müller's canal. Seeing then that diseases of the uterus are of such frequent occurrence, it should not seem surprising that the Fallopian tube of either side should often become implicated from mere continuity of tissue; considering also that they have the same serous membrane covering them, and also a continuous mucous membrane lining their cavities. I have come to consider that the diseased tubes may arise from both these factors: in the latter case, *i.e.*, from the inside, by mere extension, in the same way in which an orchitis arises after a gonorrhœa in the male; in the former case, *i.e.*, from the outside, as a form of pelvic peritonitis or ovaritis extending to the serous covering of the tubes.

The reason why pus is not found in the uterine cavity in the same way or frequency as it is in the tubes, may be ascribed to one or both of two facts:—First, the uterine outlet or inner os, remaining patent, allows any purulent secretion to be continually escaping, whereas the tubes become obliterated at each end; and second, the amount of areolar tissue in the uterine wall is very small indeed as compared with that in the tubes. Hence suppuration is much more rare in the uterus.

Of the causes of these diseases, I am only too sorry that I am unable to communicate very much upon the

subject. I consider them to be more frequent in the married than in the single. The history given by patients very frequently points, as in many other pelvic ailments, to some form of pelvic inflammation, or tedious convalescence after a confinement or a miscarriage. Gonorrhœa has been said by Dr. Edis and others, to be a cause. I think it very likely that it is a frequent cause. Dr. Edis says, that "latent gonorrhœa will explain many of the obscure cases of peritonitis occurring in newly married women." M. Courty, of Montpellier, in his recent work, translated by Dr. Agnes McLaren, notices the same thing. It is, therefore, a question for us to answer, how frequently women are either sterile or the subjects of Fallopian tube disease, whose husbands may have sometime previously had an attack of gonorrhœa, but who were not necessarily affected by it in an appreciable form at the time of marriage. I can imagine that sometimes the abuse of pessaries, especially intra-uterine ones, may be answerable for some amount of pelvic peritonitis and adhesions of the pelvic contents. Dr. Alfred H. Carter tells me that he has seen two cases of pyosalpynx associated with acute rheumatism, and frequently recurring rheumatic pains. It has appeared to me that in the large majority of cases the inflammation, which commences the disorder, has been of a septic character. Ovaritis is frequently coexisting with it, and is probably produced by the same cause or causes. In the causation, menorrhagia must not be left out of sight, seeing that it is so frequently an accompaniment of both hydro and pyosalpynx, and also that the existence of menstruation is more dependent upon the presence of the Fallopian tubes than of the ovaries. Recent experience, especially in Birmingham, has seemed to prove conclusively, that removal of the ovaries alone can not be relied upon

to arrest menstruation, save in exceptional cases, with the same certainty as the removal of the tubes, alone or along with the ovaries, is known to do.

The first effect of inflammation seems to be to cause an obliteration of both the uterine end, and the fimbriated end of the tube, giving rise subsequently to an accumulation of the abnormal fluid, either serum or pus, and to the well-known worm-like or sausage-shaped distension. The pus may partake of the character of a muco-purulent fluid, of true laudable pus, or of most offensive pus. When it is of the latter kind I have thought it has been the result of a long standing disease; the patient having from time to time had recurring attacks of inflammation, until at length the tube bursts spontaneously, or, as has been the case of late, if diagnosed in time, surgery steps in and removes the putrid mass, thereby most probably saving a life otherwise doomed.

The cases of hydrosalpinx, of course, are not of the same serious nature as those in which pus has formed; I think that in the past they have been sometimes mistaken for a so called enlarged wolffian cyst, where a single tapping has sufficed for a cure: in such a case the escape of some of the fluid into the peritoneum, during an operation by abdominal section, would be of no consequence. I have proved the truth of this in several instances where the serous tube burst in extracting it through the abdominal wound: it is, of course, possible that the serous contents may sometimes become absorbed, and the patient recover spontaneously. But this result presupposes that no adhesions have taken place, which might be the cause of much after pain, sterility or menstrual disorder. If these last named conditions are present with the tumour, or even after the tumour has disappeared, we must, I think, come to the conclusion

that something more will require to be done than trusting to nature, and to purely medical means, and our hope and confidence will look to surgery.

In the much more serious affection where pus is expected to exist, as shewn by the state of the patient, her temperature, and the condition of things in the pelvis, temporising with nature or physic is not only worse than useless, it is harmful, for it allows that time to pass away in which removal might have been successfully effected. Tapping, *per vaginam*, would be a dangerous experiment : on account of a liability of some of the pus to escape into the peritoneum, and also of the difficulty of getting it away if very thick, as is sometimes the case. With two large bags full of pus in the pelvis, each say the size of a small orange, it is difficult to conceive of absorption spontaneously occurring.

If allowed to go on unchecked, one of three results is likely to happen. First, absorption of the fluid, with recovery ; this is very unlikely, if not impossible in the case of pyosalpynx. Second, a state of chronic invalidism, with inability to fulfil the duties of life, constant pain, frequent high temperatures or rigors, etc., etc. ; and third, bursting of the sac—this, if discharged into the rectum, would have a curative tendency ; but if into the peritoneal cavity, it would be certainly fatal. And that this danger is not a very remote one, will be seen from the following cases.

Case I.—Patient had menorrhagia, with a small lump in right side of pelvis. Tents were inserted, and the uterine cavity explored ; nitric acid being applied to the interior. The patient died of septicæmia, with abdominal distension. At the *post mortem*, a pyosalpynx on the right side was discovered, shewing distinctly its sac and a point at which it had burst, with the contents free in the peritoneal cavity.

Case II.—In one of my first operations of this kind I found that the anterior wall of the sac, on the right side, was composed, at one spot, of only a single layer of membrane, thin enough to be almost transparent, and which must have given way on the slightest pressure; such, for instance, as romping with a little child on the lap, etc. etc.

Case III.—In a patient recently operated on, the left distension gave vent to a quantity of stinking pus immediately on my touching it with my fingers, using scarcely any pressure at all. Here, a very little external pressure, even examination by double palpation, might have caused a rupture.

In reference to the diagnosis of an enlarged and distended tube, this must be frequently to some extent presumptive, founded upon the clinical history and the physical signs. There will be found a tumour of not very considerable size in the position of the Fallopian tube on one or both sides of the uterus, or, if larger, it may be felt almost wholly in Douglas's space. A small ovarian cyst, a phlegmon in the broad ligament, or a small hæmatocele, are the affections which would most generally be taken for it; but I have been able in a certain number of cases to say beforehand that the tumour felt was most likely a distended tube, in which the result proved that I was correct. In the acute forms, the parts around the uterus may be felt to be boggy, with more or less of fixation of that organ. In the more chronic forms, the uterus may be quite free and mobile, and the tube felt, more or less tender, as a small tumour, floating about apparently quite freely. If the tumour is larger, say the size of a small orange or more, and is to some extent fixed by adhesions, the result of previous inflammatory attacks, the uterus is less free, and may be pushed to one or other

side. With the patient lying on her back, and especially if thin with a lax abdominal wall, important aid may be also gained by the use of double palpation, *i.e.*, with the finger of one hand in the vagina, and the other hand exercising pressure outside through the abdominal wall. The clinical history, in addition, will give a considerable amount of aid in the diagnosis.

In some instances, I feel sure there is nothing to be felt in the pelvis before operation, and we have nothing to guide us but the more or less constant pain and recurring attacks of inflammation; each attack making the adhesions stronger and more extensive, and rendering the subsequent removal by operation more difficult, and, therefore, more dangerous.

In performing abdominal section for the removal of these tumours the incision may generally be a short one, say two inches, or just enough to insert the fore and middle fingers of the left hand. It would seem as if an enlarged experience enabled the operator to separate the adhesions with greater facility and that an increased "tactus eruditus" taught him the more easily to distinguish the line between ovary or tube and the surrounding parts. The omentum is sometimes found to be troublesome, getting entangled among the fingers. If there is any doubt in the surgeon's mind as to the exact relation of the parts, I think it is best to take the fundus uteri as a landmark, and by tracing outwards, on either side, the ovary, tube, and broad ligament can generally be accurately mapped out. If the tumour, after being separated from its bed of adhesions, is large and cannot be brought out through the short opening, it is often a good plan to aspirate it, especially if the contents are serous, when the collapsed tube comes outside readily. If any of the serum or pus escapes into the pelvis, especially the latter, it is of

the utmost importance to make a most complete "toilette du peritoine:" in fact the patient's safety depends more upon this than perhaps all other details in the operation put together. I would say, sponge, sponge, sponge! I do not think it necessary to wash out the pelvis, as I did at one time in my practice; I think dry sponging is quite as effective to prevent mischief following. There need be no fear of too much sponging, but every fear of too little. If there has been no escape of pus, and if I am sure also of no blood being present, I make it a rule to close the abdominal wound completely: otherwise, I insert a glass drainage tube, and results have justified the practice followed.

I have of late omitted the use of the spray in performing abdominal operations. For five years I have been an ardent, perhaps a bigoted, believer in the necessity for the use of the spray in operations involving the opening of the peritoneum; but having seen its disuse commenced by Keith, Tait, Bantock, and others, with equally good results as under its use, I have been unable to close my eyes to what has seemed to me to be the inexorable logic of facts. I would sum up the conclusions to which my observation has led me on this part of the subject by saying that increased operative experience and extreme cleanliness, in its fullest sense, are the two main factors which contribute to successful practice. This doctrine of cleanliness has doubtless been brought about very largely indeed, if not wholly, by the work which Lister has done; and I understand it to include many items, such as abundant use of water, most careful attention to sponging, arrest of hæmorrhage, and drainage where necessary.

The points that have most strongly impressed me, and which I would impress also upon others, are that if there

is the slightest doubt, before closing up the wound, as to the presence of fluid or the likelihood of much future oozing of bloody serum you must sponge very thoroughly indeed, and will probably require a drainage tube. Germs, even putrefactive germs, there probably may be often left behind, but I would leave behind as few as possible; and those that are left, I suppose, become innocuous, or are digested, or absorbed by the serous peritoneum without harm, provided that no fluid is allowed to be retained in the abdominal cavity, in which they would find a suitable soil for increase.

The remarkable and well-known frequency with which both tubes will be found affected with disease at the same time, renders it necessary to remove both at the time of operation; and I would go so far as to say that, when one has been removed, it is generally best to remove the other one also, even if it be found at the time of operation to be apparently healthy, as the probability is that it would sooner or later become affected in the same way as its fellow. By the double operation the capacity for child-bearing cannot be affected one way or the other, for with obliterated and distended tubes, and the normal relation between ovaries and tubes being probably destroyed, it is not likely that conception could occur; hence the operation cannot be said to induce sterility: it cannot bring about what was in existence before.

There are some cases which have been classified as pelvic cellulitis, or pelvic abscess which, I feel sure would, if their exact relations could be made out, come under the head of pyosalpynx, or pus so contained that it could be removed, and the operative treatment in such cases is gradually throwing a considerable amount of light on pelvic suppuration, so that many hitherto incurable cases may be cured. It does seem to me to be very important that

we should recognise the serious position in which patients are placed who are having from time to time recurrent attacks of pelvic inflammation, and that we should step in in time and remove either the cause or the results of the recurring attacks.

REVIEWS.

INTERNATIONAL ENCYCLOPÆDIA OF SURGERY.*

(FIRST NOTICE.)

WE may commence by stating that the present volume of this large and important surgical work fully realises the expectations formed by a perusal of its predecessor, in the material it contains, in the illustrations it offers, and the general style in which the book is got up.

Article I. relates to contusions. The author is Dr. Hunter McGuire, Emeritus Professor of Surgery in the Medical College of Virginia, Richmond. The subject is not a heavy one, and does not give the author a large scope.

The question of wounds is considered under general and special headings. Dealing with the former, the article of Mr. Bryant, of Guy's Hospital, will probably excite feelings a little mixed. That portion which deals with the process of repair is nothing more or less than a pathological jumble, in which facts, new and old, form a combination altogether unsatisfactory. As might be expected, on the question of treatment, the practical surgeon of large and varied experience is at once strongly marked. The first dressing of an operation, it is stated, should not be changed for a week; we can only wish that such a dictum could be taken as the rule and not as the exception. The directions for the second dressing are particularly minute and thorough. The so-called "open method" of wound treatment, is not regarded with favour,

* "The International Encyclopædia of Surgery." Edited by John Ashurst, Jun., M.D. Vol. II. London: Macmillan & Co. 1882.

except in wounds of the face. With regard to Listerism, those who arrogate to themselves the title of antiseptic surgeons are considered very naughty boys, and are severely lectured: firstly, for their credulity; and secondly, for boldly practising what they believe to be true, and performing all sorts of new-fangled operations. Mr. Lister is, however, smoothed gently down for "having helped more than any one else to establish the value of antiseptic drugs and antiseptic precautions in the practice of surgery all over the world." Poisoned wounds including those caused by dissections, reptiles, insects, etc., are dealt with by Dr. J. H. Packard, of Philadelphia. Sabre, bayonet, and arrow wounds, especially the latter, are interestingly considered by Surgeon Bill, of the U. S. Army. The subject of gunshot wounds was placed in the hands of Professor Otis, the distinguished author of the *Surgical History of the American War*; but owing to his death, Professor Conner, of Ohio, Cincinnati, has compiled an article conspicuous for its ability, and showing extensive knowledge, both practical and theoretical.

Mr. Watson Cheyne's article gives a good summary of the antiseptic plan of treating wounds; it is a subject with which he has particularly identified himself, and no one has a sounder knowledge of it, excepting Mr. Lister.

Mr. Howard Marsh, of St. Bartholomew's Hospital, treats of abscesses satisfactorily, if we omit his classification; for while objecting to the old terms, the writer would arrange abscesses according to some general constitutional conditions. It may be prejudice, but we prefer the older phraseology, thinking it is better for working purposes. On the question of treatment, we are glad to find that the writer is not greatly impressed with the unscientific procedure called hyper-distension, and does not cordially recommend it for every day practice.

On the effects of heat, Dr. T. G. Morton, of Philadelphia, discards Dieffenbach's classification of burns as being cumbersome, and substitutes the following three degrees for practical guidance. 1st.—Irritation or inflammation of the skin without vesicles. 2nd.—Inflammation of the skin and formation of vesicles and bullæ. 3rd.—Carbonization of the tissues, in part or altogether.

Attention is also directed to the appearance of albumen in the urine of those suffering from burns of the second degree.