Cases of tuberculous disease of the uterine appendages and peritoneum / by Alban Doran.

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CASES OF TUBERCULOUS DISEASE OF THE UTERINE APPENDAGES AND PERITONEUM.[1]

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PRIMARY tuberculous disease of the peritoneum is a disorder more or less hypothetical, in the eyes of the pathologist. This implies that the primary disease, of necessity tuberculous, lies somewhere else, a matter of great importance to the physician and surgeon.

We all know the insidious character of tuberculous peritonitis; diagnosis is often difficult. In this communication I shall assume that the disease is correctly diagnosed, or at least strongly suspected, as arising in the genital tract, and I limit my observations to female patients.

How far the treatment should be expectant and how far operative I cannot precisely determine. That is why I have chosen the subject of tuberculous disease of the female internal organs. I seek other opinions.

Purely expectant treatment is not always satisfactory. Tubercle of the appendages may, in its later stages, involve the worst complications so familiar in tabes mesenterica, with the additional torments of fistulous tracks in the groins and vaginal fornices. The presence of tubercle in the ovaries and tubes certainly endangers organs and parts where tubercle may kill or cripple. Again, experience shows that operative measures do good, even though it is not certain how that good is done.

On the other hand, we must be slow in urging operations lest we become operators rather than surgeons. In many parts of the Continent most unjustifiable measures are taken in cases of chronic affections of the appendages, tubercle not excluded. The uterus, tubes, and ovaries are taken out or the uterus alone extirpated through the vagina, the operator proudly boasting that he is thus enabled to empty cavities full of pus. Plainly this is operating, not surgery. I read of a typical case of the kind in a foreign medical paper recently. A surgeon operated on a woman who had a large swelling on each side of her uterus—clearly disease of the appendages, but whether tuberculous, gonorrhœal, or the result of puerperal mischief remains uncertain. The question seems to have been overlooked as though unimportant. He removed the uterus and the right tube and ovary, but the left appendages were so firmly adherent to the pelvic wall and other parts that they were left behind. A few days after

[1] Read at the East Anglian Branch (British Medical Association) Jubilee Meeting.

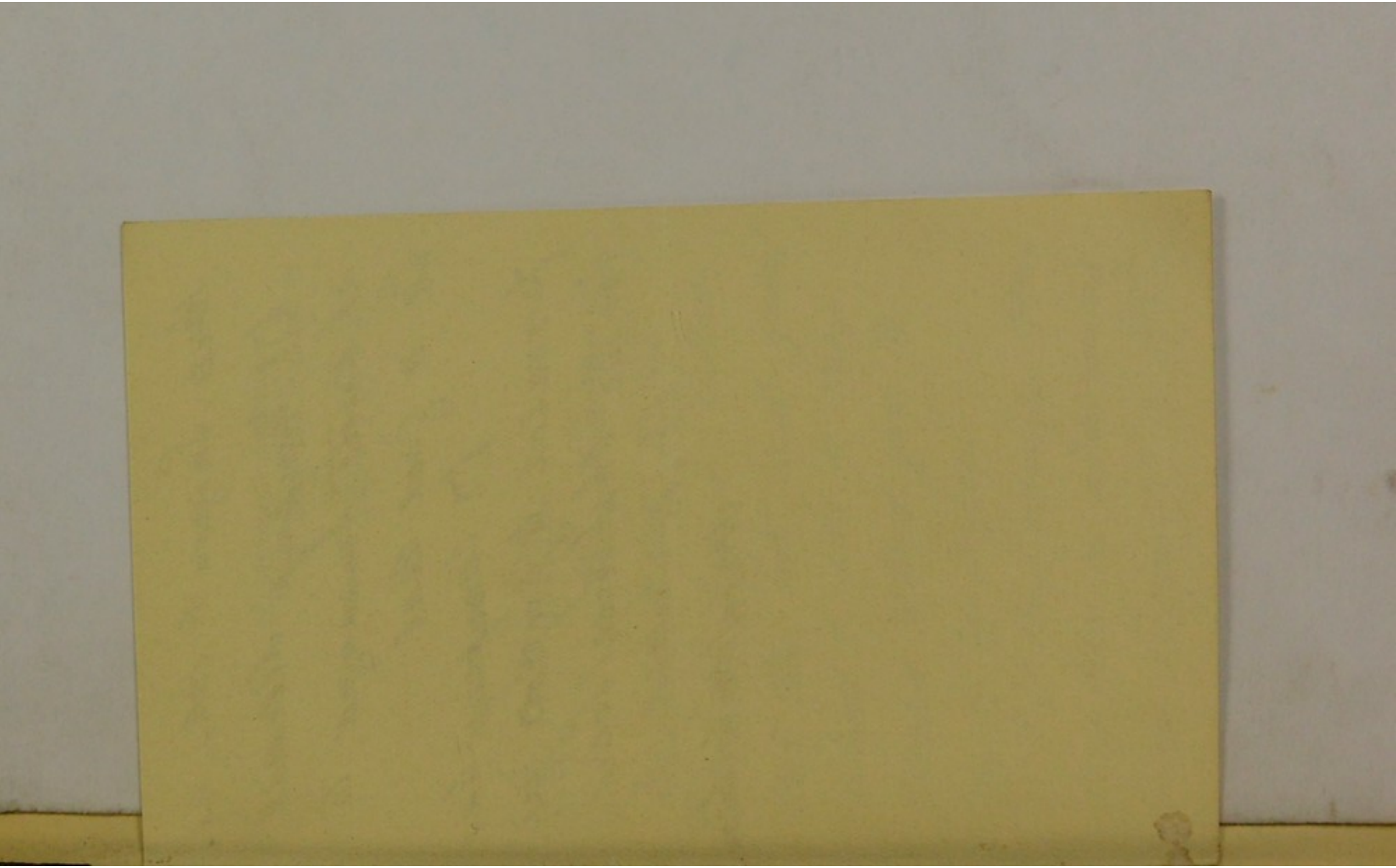
the operation urine began to dribble from the vagina. Some months later the patient entered another hospital, with severe incontinence of urine, a large swelling in the right loin, and another in the left iliac fossa. The temperature rose to over 105° F. The bladder was found to be uninjured; the urine issued from a fistula in the right ureter. The right kidney was removed, advanced pyonephrosis being discovered. The patient recovered, and was quite well a year later. Observe that the swelling in the left iliac fossa, which was half the reason, so to speak, for the first operation, was left to itself, and the operator has omitted all description of its present condition.

Experience shows that tuberculous disease is not rare in the ovaries and tubes of young subjects where there is a hereditary tendency to tubercle. The disease may certainly occur in virgins. Professor Bumm, of Würzburg, a distinguished bacteriologist, has shown that the gonoccoccus damages the tubal epithelium, and thus a barrier of defence is taken away from deeper tissues. The appearance of tuberculous disease of the testis, after gonorrhœal or traumatic orchitis in sickly youths, is explained in the same manner. The theory is at least plausible. It does not explain how tuberculous disease of the tubes occurs in virgins. Catarrh of the entire genital tract is not rare, and it is possible that it may also favour tuberculous disease by damaging superficial structures.

Tubercle of the appendages may be limited for some time to those parts without setting up ascites, whilst in other cases ascites is an early symptom.

The first, or localised, form bears a strong resemblance to ordinary inflammatory disease of the tubes and ovaries. When advanced, it is certainly a case for operative measures. Last winter I had under my care two young women with tuberculous histories, from whom I removed the appendages. The tube and ovary on each side ran into each other, or rather communicated by large cavities full of cheesy pus. The patients, who had both been invalids for several years, were restored to health. The removal of organs in this condition suppresses a focus of general peritoneal infection. Of course, I do not set up such cases as an excuse for removing recently inflamed appendages in sickly girls. A close scrutiny into the family history, and rest in bed for a sufficiently long period to allow any case of ordinary inflammation to improve, are first required.

Tubercle of the appendages with ascites is a most interesting disease, and probably not rare. It is hard to distinguish from the passive hydroperitoneum also observed in sickly women, possibly set up by catarrh of the tubes, the discharge escaping from the ostia. The encysted dropsy, due to tubercle, is especially puzzling. As a rule, I find that tuberculous peritonitis involves this variety of ascites, as coils of intestine become adherent and limit the effusion. A cyst develops above the hypogastrium. The uterus is free yet the cyst presses down upon it; hence, very naturally, the disease may be diagnosed as an ovarian cyst. A tuberculous subject may suffer from the common cystoma of the ovary like any other woman. In short, there is no absolute clinical distinction between an ovarian cyst and an encysted dropsy in a tuberculous subject. Rules for distinction may be laid down, but in practice the finger, hand, and sound may fail to decide the truth.



House Surgeon & later as
Dr. Champneys Assistant
at Barts I managed to
see a good deal.
Dr. Champneys has
promised to propose me
for the Obstetrical Society
Yours Sincerely
Harold Wilson

TELEPHONE
2358 MAYFAIR.

50, WELBECK STREET,
CAVENDISH SQUARE, W.

May 27. 1906.

Dear Mr Doran.

Many thanks for your kind letter & the enclosed papers - I have read them both with great interest & will be very pleased to send you a copy of my paper -

I have always been very keen on abdominal before Surgery & as Mr Lipp's

As a result, the abdomen has often been opened in cases of encysted dropsy, ovarian cyst having been diagnosed. In most of these cases, the abdominal wound being closed, the patients have recovered more or less completely. Dr. Parker Syms, of New York, has collected a large number of cases where exploratory operations of this kind have resulted in cure, even when pulmonary phthisis was present. These results were observed, it must be said, in cases of tuberculous peritonitis due to other causes than tubal and ovarian disease. Poppert recently operated for intestinal obstruction in a girl and found widespread peritonitis with abundant tuberculous deposit: all this disappeared, and the patient recovered perfectly. He collected five similar cases where tuberculous peritonitis was not discovered until the abdomen was opened for intestinal obstruction.

Two remarkable cases have occurred in my own experience. The first is related in full in the *Transactions of the Obstetrical Society of London*. A girl, aged 16, had a fluctuating swelling in the hypogastrium. Her habits had been irregular. She had a brother who died of tuberculosis. The uterus lay high in the pelvis; it was movable, but every movement of the fluctuating swelling was communicated to the sound. I made an exploratory incision and found a thick spongy, yellow substance under the peritoneum. I suspected that the substance might be sarcomatous, as ovarian sarcoma is frequent in young girls, and is usually associated with amenorrhœa, as in her case. I closed the wound and did not expect her to survive, but to my surprise I found her in excellent health a few months later. The fluctuation had disappeared and the abdomen was flat. Afterwards the girl became subject to pulmonary phthisis. She died a little more than three years after the exploratory incision. The Fallopian tubes were swollen, forming oval fluctuating cysts; both ovaries were much enlarged and converted into cysts filled with dirty yellow pultaceous material. In all probability the disease began as tuberculous salpingitis, which set up tuberculous peritonitis. The abdominal incision relieved the peritonitis; the thick yellow deposit under the peritoneum no longer existed when the *post-mortem* examination was made, and the encysted collection of fluid had entirely disappeared. This case demonstrates, in part at least, the disappearance of tuberculous deposit after incision.

In another particularly bad case the patient was a tall and apparently strong girl, aged 21; but one sister died of phthisis and one brother had hæmoptysis, dying ultimately of tuberculous disease of the intestines. The patient herself had perityphlitis when an infant, a pin escaping out of an abscess which discharged through the right groin. In 1889 she overworked herself preparing for a Civil Service examination, and her health failed permanently. Early in the summer of 1891 a fluctuating tumour developed in the hypogastrium, reaching to the umbilicus; it was continuous with a pelvic swelling which pushed the uterus to the left. The left knee became painful. The abdominal swelling fluctuated in size. Under the care of Mr. Hatfield, of Forest Hill, her general health improved.

On October 15th, 1891, I opened the abdominal cavity. I discovered extensive tuberculous disease of the peritoneum and intestines, which were matted together. The pelvic

viscera were deeply involved. On puncturing a membrane, which really consisted of tuberculous deposit, much cheesy matter escaped. I reached the bottom of Douglas's pouch, and passed a drainage tube into it, much to my present regret, but there was considerable oozing of blood. The tube was removed in twenty-two hours. Unfortunately, the track of the tube opened up a week after the operation, and much cheesy pus escaped. It was fœtid, and I feared that a fæcal fistula had formed. Fortunately this was not the case, and solid fæces and flatus passed freely from the rectum soon afterwards without any change in the discharge. I had, nevertheless, great trouble with the fistula, but directly I employed an emulsion of iodoform in glycerine as a daily injection, the discharge diminished and the patient's general health improved. The knee, however, remained painful and slightly swollen, and I encased it in a poroplastic splint. The wound at length closed, and the patient went into the country. From time to time there is slight discharge from the wound, but there has been no sign of ascites or advance of the abdominal disease, though the knee is the seat of chronic synovitis.

This was a particularly bad case, and very instructive. My great regret is that I passed a drainage tube into the wound. A tuberculous peritoneum does not tolerate the irritation of that appliance, which is so well borne and so necessary after the removal of strongly adherent tumours. I know of two cases, one under the care of an English and another under a French surgeon, where fæcal fistula developed shortly after the tube was removed. In the first case the patient died of exhaustion; in the second she recovered, and the peritoneal tuberculous disease disappeared. In another case of peritonitis where I assisted, I feel no doubt that the disease was tuberculous; the wound was drained, and six or seven months later the drainage track opened, and fæces discharged; the patient soon died. In the French case, which recovered, the intestine gave way at a point where a small mass of tubercle lay on its serous coat. This probably explains the other cases; the tube irritating a point already diseased. Observe that in the two cases above noted where I removed tuberculous uterine appendages, the disease being localised to those structures, I had no further trouble whatever. Again, in the young girl who died of phthisis, where I simply cut into a dense layer of tuberculous deposit and did not drain, the abdominal disease disappeared, and the patient remained in fair health for two years, dying, three years after the operation, of pulmonary phthisis.

The right treatment, when it is evident that the disease is tuberculous and involves the peritoneum beyond the investment of the uterus and tubes, is to close the wound at once. If cheesy fluid be present it must be allowed to escape, and iodoform emulsion[2] should be poured in, for the tuberculous discharge, when air is admitted, is very apt to get septic, and the emulsion has a distinctly beneficial effect. Patients with the disease in question are little liable to iodoform poisoning. Mr. Barker, of University College Hospital, finds

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[2] Iodoform (fine crystals) 10 parts; rectified spirit quant. suff. to make damp; distilled water 20 parts; glycerine 70 parts. Rub the iodoform and spirit together in a sterilised mortar, add the water, using the pestle well, and then by degrees pour in the glycerine. If mixed badly, it will clot.

the emulsion excellent in fœtid perityphlitis. Trendelenburg has used it with great success in strumous disease of joints.

Experience, as König and Parker Sims have shown, has established the fact that tuberculous peritonitis is often cured by simple incision through the parietes. This kind of treatment must be held as empirical, none of the theories devised for its explanation are satisfactory. Lauenstein suggested that the cure is due to the mere withdrawal of the fluid, since the tubercle bacillus does not flourish except in the presence of much moisture. Yet in many of the more successful cases no attempt was made to empty out the effused fluid completely—a very difficult task when actually undertaken. In one of my own cases related to-day I did not even reach the fluid; nevertheless it disappeared, as well as the solid deposit into which I passed my knife.

I have laid down what I believe should be done and what avoided, and in conclusion I must note that the earlier the peritoneum is opened the better the chance of relief, and the less the risk of extension of tuberculous changes to the lungs and the joints. In general practice early diagnosis is relatively easy when the family history is at hand. No doubt cod-liver oil may arrest the disease, but if it does not yield to remedies incision of the peritoneum becomes desirable.

Menstruation in Tubercular disease

Note 1 Lettington amenorrh.

2 Rhoden. Scanty, irreg.

3 Wright. Free clots

4 Howard - Scanty

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