Haemorrhage from the Fallopian tube without evidence of tubal gestation / shown by Alban Doran.

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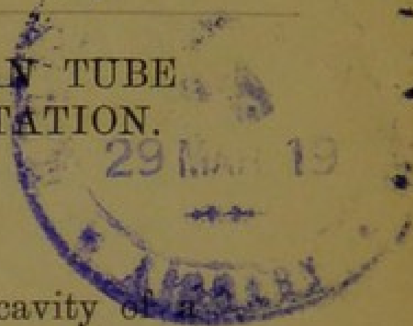
HÆMORRHAGE FROM THE FALLOPIAN TUBE WITHOUT EVIDENCE OF TUBAL GESTATION.



Shown by ALBAN DORAN, F.R.C.S.

THE presence of blood in the peritoneal cavity of a woman is a matter of high importance, not only from a clinical standpoint, but also for medico-legal reasons. The very mention of this condition suggests extra-uterine pregnancy. Experience has shown that, putting aside accidents in uterine pregnancy and parturition, that abnormal form of gestation is almost invariably the cause of the hæmorrhage. Are there any exceptions? I believe that there are, and that this specimen may be classed amongst them. Hence I may be pardoned for dwelling on the appearances which it presents at some length.

A. C—, aged 25, was admitted into the Samaritan Free Hospital on November 4th, 1897. She was well nourished but markedly anæmic. Two and a half years ago she was married, and had only once been pregnant, miscarrying at the third month in May, 1896. Menstruation was never regular, the flow varying greatly in amount. Twelve weeks before admission severe bearing-down pains set in, with free show which could not be checked. On October 6th Dr. Frederic McCann saw her for the first time, and detected a mass in the right fornix. No history of the passage of any structure like a decidua could be obtained.

The patient was sent into my wards because the mass had distinctly increased in size since October 6th. I found no changes characteristic of pregnancy. There was an elastic and distinctly tender mass in the right fornix. The uterus was hardly enlarged, and lay in its

McIlroy (Louise) Torsion of the Fallopian Tube as a Factor in the Etiology of Haematosalpinx apart from Ectopic Pregnancy. J. of O. & G. Vol 18. p. 368. (note on above p. 372.)

normal axis. I would not, under the circumstances, pass a sound. There was much sanious discharge from the os. The pulse was 84, regular and small; the temperature remained normal between November 4th and 13th. The urine, drawn off with the catheter to avoid the blood which constantly oozed from the os uteri, was almost colourless, very acid, sp. gr. 1006, and free from albumen and excess of phosphates. The patient had never been laid up with severe illness, and after the miscarriage in May, 1896, she kept her bed for a fortnight and recovered completely, so that she had evidently not neglected herself.

A week's rest produced no effect whatever on the local condition. The tenderness was noteworthy, as the sequel showed that the mass was a nerveless structure, so that it was its surroundings that were tender.

On November 13th, 1897, I made an exploratory incision, the patient being placed in Trendelenburg's position. I saw a mass of small intestine adherent to something to the right of and behind the uterus. On freeing the gut I exposed a reddish-brown solid mass, into which the right Fallopian tube appeared to run. Posteriorly the mass adhered to the sigmoid flexure and rectum. I passed my hand carefully under the mass, and succeeded in drawing it up with the tube and ovary; they were then removed together. The left ovary was large and succulent, as usual in a healthy young woman, the left tube quite normal. There was no sign of any effusion of blood into the peritoneal cavity beyond the mass, or into the parametrium. Convalescence proceeded steadily, and the patient was quite strong when she left the hospital.

I sent the right tube and ovary and the attached tumour, now exhibited, to the College of Surgeons. On cutting open the tumour it appeared to consist of clot. A section was made close to its attachment to the fimbriæ of the tube, including tubal tissue. Under the microscope no chorionic villi nor decidual cells could be found.

695.K
567.B (Ralins)

The tumour, as now seen, forms a pyramidal mass with

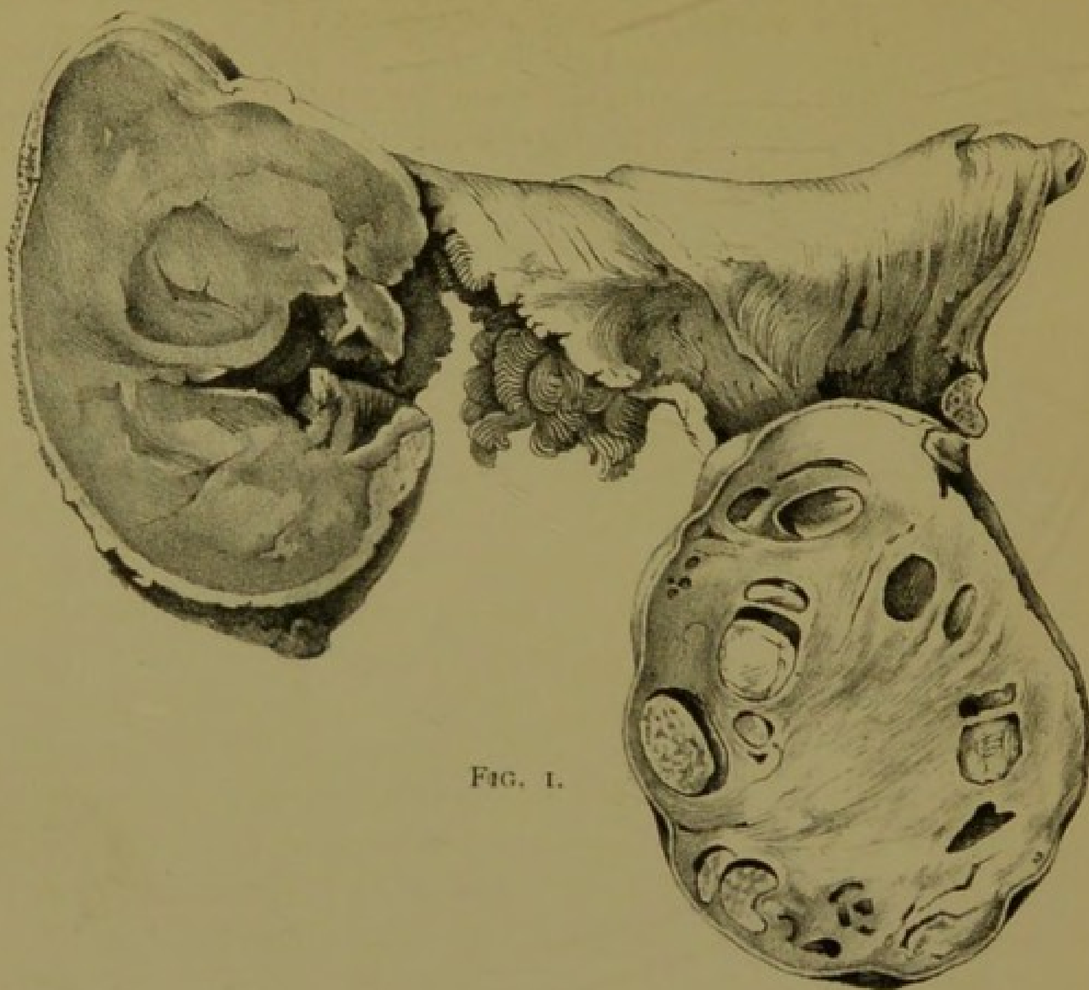


Fig. 1.

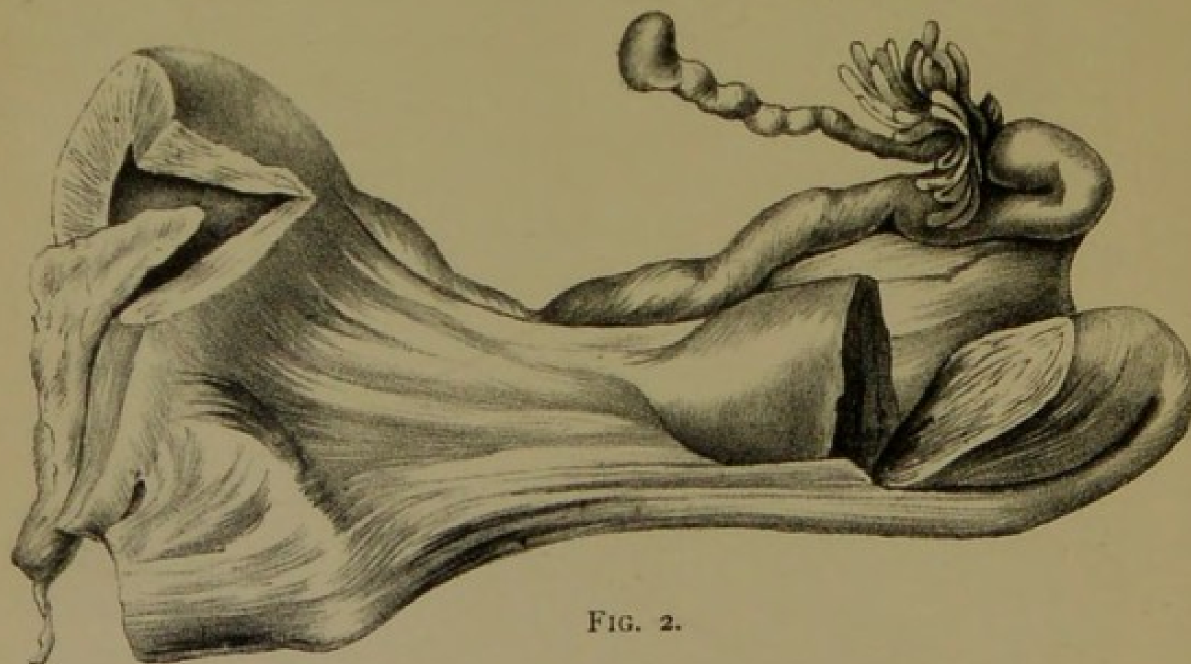


Fig. 2.

HÆMORRHAGE FROM THE FALLOPIAN TUBES WITHOUT EVIDENCE OF EXTRA-UTERINE GESTATION. (Alban Doran.)

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convex surfaces. The apex is firmly incorporated with the fimbriæ of the tube above the ostium; the base measures 2½ inches. The interior appears on section as solid coagulum, old and firm towards the base, soft and recent at the apex, which lies close to the tubal ostium. The fimbriæ of the tube are normal, the canal shows no sign of dilatation or inflammation, and the ostium is not dilated. The mesosalpinx is perfectly free from any abnormal condition. The ovary is large, two inches in vertical and an inch and a half in transverse diameter. On its cut surface are several follicles about an eighth of an inch in diameter, full of half-decolourised clot, but I could not find a corpus luteum. (Fig. 1.)

The most positive feature in this case is the hæmorrhage from the tube, self-evident after a glance at the specimen. This accident is usually the result of tubal gestation. In this case there was no positive clinical evidence of gestation. The irregularity of the catamenia, which had been present for years, greatly obscured diagnosis. Intrauterine pregnancy ending in very early abortion was possible, but could not be proved; no decidua was ever detected, nor was there evidence of enlargement of the uterus. Early tubal gestation was at once suggested by the hæmorrhage. But the tube looked absolutely normal. Many months after a tubal abortion a tube might conceivably undergo perfect involution. In this instance the local disturbance was quite recent, yet the tube appeared healthy as it lay in the pelvis, and was proved healthy when examined after removal. Above all, the ostium was not dilated. Again, as the ostium was as free from any sign of obstruction as it was free from any trace of dilatation, the question of hæmatosalpinx ("sactosalpinx hæmorrhagica," as Martin and Orthmann call it) is precluded.

Whence then came the blood? Was it an exudation from the surface of a congested mucous membrane, or was it the result of uterine hæmorrhage passing into the tube instead of into the vagina?

I must admit that I am very suspicious of alleged cases of hæmorrhage from the tube into the peritoneum not due to ectopic gestation. On the ground of accurate observation modern teaching encourages that suspicion. To take the opinion of two distinguished teachers who have issued treatises within the present year, we find that our old president, Dr. Herman, says, "I am not satisfied that there is such a condition as metrorrhagic hæmatocele, meaning by that, hæmorrhage from the uterus escaping by the Fallopian tube into the peritoneum. I think that cases appearing to be such are either tubal gestation, or cases of hæmorrhage from the tube itself of unknown causation."*

Labadie-Lagrave insists on the very valid objections to Bernutz and Guérin's theory of reflux of blood into the peritoneum from the uterus. Trousseau and Fernerly traced hæmorrhage out of the ostium to a kind of epistaxis, an abnormal increase of anatomical oozing. Labadie-Lagrave attaches no importance to this hypothesis.†

The earlier theories were very plausible, menorrhagia from the tube or epistaxis sounding quite natural, but they were advanced before the days when the microscope was made to reveal chorionic villi in clots.

Yet, though it is admitted that the great majority of cases of hæmatosalpinx are due to tubal gestation, and that nearly all cases of hæmorrhage from the ostium signify tubal abortion, exceptional conditions are possible. I made use of the term "epistaxis" above. Dr. Walter Griffith showed us here ten years ago the internal organs from a single nulliparous girl, aged 18, who died from uncontrollable epistaxis and menorrhagia.‡ The uterine

* 'Diseases of Women,' 1898, p. 308.

† Labadie-Lagrave et F. Legueu, 'Traité Médico-Chirurgical de Gynécologie,' 1898, pp. 1119, 1120, and 1122.

‡ "Hæmatoma and Hæmatosalpinx," 'Trans. Obstet. Soc.,' vol. xxix, p. 397. The specimen is in the museum, St. Bartholomew's Hospital, Path. Series, No. 2934A. The next specimen, No. 2934B, is very similar. A tri-

cavity contained a blood-clot which extended along the Fallopian tubes, and on the right side projected beyond the fimbriated extremity. As the patient was a young nulliparous girl, the tube was much smaller and less developed than in the example which I exhibit this evening. (Fig. 2.)

In the catalogue of specimens in the museum of St. Bartholomew's Hospital * there is an important piece of evidence not included in Dr. Griffith's original report:

"This projection of the clot (beyond the fimbriated extremity) is due to the narrowing of the calibre (of the tube) owing to the action of the spirit, *as it did not occur in the fresh specimen.*"

On examining the specimen I find that a vermiform clot, about two inches long, hangs out of the ostium. Even if it had protruded from the tube before death, it would in no way have resembled the large clot seen in the example of tubal hæmorrhage which I exhibit this evening. Again, with the kind permission of Dr. Calvert I have been able to look up the original report of the case from which Dr. Griffith's specimen was taken, and find that the peritoneum is reported as "normal," and it is clear that not a drop of blood escaped into its cavity.†

This fact is really admitted by Dr. Griffith, for though he does not state that the clot hanging from the ostium was squeezed out after death by the action of spirit, he remarks quite reasonably that "there was no hæmatocele in this case, but a little more hæmorrhage would have caused one." In short, his case clearly shows that there

angular clot occupies the uterus and extends into both tubes. The patient, a virgin aged 20, died of uterine hæmorrhage. See 'St. Bart.'s Hosp. Rep.,' vol. xxv, 1889, p. 334.

* This specimen is described under "Specimens added to the Museum," in the 'St. Bart.'s Hosp. Rep.,' vol. xxii, 1886, p. 399; also 'Catalogue of Museum: Addenda,' pt. 5, No. 2934A.

† 'St. Bartholomew's Hospital Register Book of Complete Cases,' vol. xii, folio 10. The stomach and intestines are also reported "normal." There was no visible disease of the internal organs except the hæmorrhage. Dr. Griffith (loc. cit.) states that no history of hæmophilia could be obtained.

can be blood in a tube which is not the seat of an abnormal pregnancy, and should the ostium remain open, that blood might easily be poured into the peritoneal cavity.

I admit that such a condition must be very rare, but the above observations suggest that it is possible. Our President* has admitted that "the time has not yet arrived for drawing a hard and fast line between blood effusions into the tube caused by tubal pregnancy, and such effusions due to other causes." The main explanation is that the effusions are very rarely due to other causes. I have endeavoured to show that this case appears to be one of those rare exceptions. It may be reasonably suspected that some of the blood which issued from the uterus as the result of some local condition other than gestation was forced not into the vagina, but along the tube and out of the ostium.

* Cullingworth, "Effusions of Blood into the Fallopian Tube," 'St. Thomas's Hosp. Rep.,' vol. xxi, 1893, p. 23. When the ostium is closed he speaks of the condition as "hæmatosalpinx," whatever the cause may be.

De Rouville: "Hématocèle rétro-utérine par rupture d'un kyste folliculaire hémorrhagique d'un ovaire microkystique présentant des lésions hémo-lymphangiomateuses." Annales de Gyn. et d'Obst. April 1908. p. 226/253. 2 attacks of 'keeping' pains; haematocele in D. pouch. Uterus pushed up. 30 dys later another attack: operation. Uterus found pushed up to pubes by mass of clot in D. pouch. Fall. tubes normal, left ovary a little sclero-cystic. A rent discovered in rt ovary, filled & covered with clot; also a bloodcyst which burst when ovary (twice normal size) was removed. The pathol. condition is expressed in title, but a trace of chorionic villi in the ovary, left F. tube quite healthy, no trace of embryo or membranes in clot. Recovered)

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H. Gayle "L'Hématocèle rétro-utérine par rupture de petits kystes hématiques de l'ovaire." Revue de Gynéc. et de Chir. Abd. Vol XIII (March-April 1909) p. 185.

Jotterand "Les hémorrhagies et l'hématocèle pelviennes extra-péritonéales sans grossesse ectopique." Thèse de Lyon 1909

[illegible]