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ABDOMINAL SECTION;

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BY

J. BRAXTON HICKS, M.D., F.R.S.,

CO-LECTURER ON MIDWIFERY; ASSISTANT-PHYSICIAN ACCOUCHEUR AT GUY'S HOSPITAL; EXAMINER IN MIDWIFERY AT UNIVERSITY OF LONDON, ETC.

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CASE OF EXTRA-UTERINE FŒTATION TREATED BY ABDOMINAL SECTION; RECOVERY.

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CO-LECTURER ON MIDWIFERY; ASSISTANT-PHYSICIAN ACCOUCHEUR AT GUY'S HOSPITAL; EXAMINER IN MIDWIFERY AT UNIVERSITY OF LONDON, ETC.

Mrs. C—, about 26 years old, was attacked with a most severe form of peritonitis in the early part of January, 1867. I had seen her about four months and a half before; she was then suffering from irregular metrorrhagia and enlarged uterus, to which had succeeded some amenorrhœa. I then considered that she was suffering from an imperfect abortion. However, it appears that from that time till the attack of peritonitis there had been complete amenorrhœa, which, indeed, has continued up to the date of this report.

I saw her a month after the peritonitis. She had then

rather improved, but was still very ill. There was great distension of the abdomen with extreme tenderness, making examination difficult. Some of the enlargement was due to tympanitis, but in the left hypogastrium there was dulness with distinct fluctuation. On the *right* side also there was dulness reaching to rather the level of the umbilicus, extending over a space of about six inches diameter, reaching downwards towards the pelvis, and apparently continuous with the swelling on left hypogastrium. Upon pressure the fingers appeared to impinge on a solid firm body, after passing through fluid, but the pain it gave made examination difficult. Examination per vaginum showed a considerable bulging on the left side of the passage, the os uteri being displaced high up to the right side. The swelling on the left was not so firm as the uterus, but somewhat yielding on pressure.

Taking into account the history, with the fact that all had come on within five months and a half (in which period it would be exceedingly rare that any growth otherwise than one connected with conception could rise so high in the abdomen), I considered that it was most probably a case of extra-uterine fœtation. I saw her again about a week after during which interval she had materially become worse; more irritative fever; tongue tending to aphthæ, and pulse from 120 to 130. She mentioned that she had had a few days before very severe pain in the tumour of the right side, which had been relieved by a rather free diarrhœa. This tumour, instead of being dull, was now resonant on percussion; and the finger impinged readily through gas on to the solid beneath. The stratum of gas seemed about half an inch thick. Thus it appeared highly probable that communication had been set up with the intestine, and that putrid decomposition had arisen. I may here remark that she had the peculiar sweet so-called hepatic breath—a state I have always found co-existing with collections of putrid matter within the system. A week after this Dr. Oldham saw the case with me, and arrived at the same conclusion as to its nature which I had entertained. There was at this examina-

tion no resonance over the tumour, but fluctuation could be detected, and beneath this the solid body.

For the course of ten days she became still worse, the pulse varying between 120 and 140 per minute. Frequent vomiting, very little food taken. Constant diarrhœa, the evacuations exceedingly putrid; tongue glazed and dry; high nervous excitability, and hepatic breath. As it was not safe to leave her longer, and as she was importunate for relief, I determined to treat the case by abdominal section, provided that the examination under chloroform should not show any reason to the contrary.

This was accordingly done on 23rd February, 1867, Dr. Tanner, of Newington Causeway, Mr. Wood, and Dr. Phillips, being present and assisting. Chloroform was given, acting quickly and excellently. When she was well under its influence, a careful examination was made. I found the greater part of the fluid in the left hypogastrium had been absorbed, and in that situation was the uterus enlarged to the size of three or four months' pregnancy. It was tilted so as to carry the os to the opposite side of the vagina. The right side tumour could now be distinctly made out, reaching towards the pelvis but not touching the uterus, its upper border nearly in contact with the liver, and its innermost border nearly to the umbilicus.

Within it an irregular body was plainly felt, having strong resemblance to a small fœtus. The centre of this tumour was the seat of the principal pain throughout the latter part of the illness. I then made a small incision in a vertical direction over the centre of the tumour, about three inches from the umbilicus; progressing very carefully when near the peritoneum, which was found fully adherent. The cyst was then opened, and a quantity of very offensive gas escaped. On looking within I saw the fœtus. The opening was then enlarged to about two inches long, before doing which, however, I passed my finger into the cyst, to discover in what direction the cyst seemed to extend. By this means I found the adhesion of the cyst to the parietes did not extend more than one inch towards the umbilicus, and that I

had only by that distance on that side escaped the edge of adhesion.

I found the head of the fœtus at the opening, which was seized by a polypus forceps. The cranial bones easily separated, and this, though it gave a little trouble, was soon overcome, and the rest of the fœtus was removed. It was putrid and remarkably offensive. A few ribs had separated, and were taken out from the cyst. The placenta was found in the lower part of cyst, and deep down, strongly attached. This was therefore left to come away afterwards. The cyst was then washed out with a weak solution of permanganate of potash, and a loose wire suture put in in the centre of the opening to prevent too much gaping, the ends merely twisted so as to be capable of being separated. A large piece of linen saturated with Condy's solution was laid over the wound. The effect of chloroform passed off just as we had completed the operation. No vomiting whatever ensued. Nothing could have been more satisfactory than its action. She was under its influence about half an hour.

The operation was over about 3 p.m., and by night she had become more settled and tranquil; the pulse still very quick, and much offensive fluid escaped from the wound.

The next morning she was much improved, but a slight attack of diarrhœa of most offensive matter occurred, which was checked by an astringent, after allowing the bowels to free themselves of the residue of that which had escaped through the internal opening. We gave her half a grain of morphia, with a little nitric acid, and chlorate of potass.

The wound discharged freely. It was washed out with weak Condy's solution; small portions of placenta coming away. Some other portions easily reached were also removed by scissors.

This process was done every day till the whole placenta had come away, which took place in small portions up till the fifth, when the largest part escaped. A slight portion came also on the sixth, which ended the process of separation of the placenta. The offensive odour at that time almost ceased, and entirely so in a few more days.

By the sixth day pus was freely escaping from the wound, and its formation was fully established by the seventh day. The edges of the wound up to this period were unhealthy, and the skin, wherever the discharge had run, was blistered. On the eighth day I injected the cyst with nitric acid and opium lotion, and applied the same to the edges of the wound, which had the effect of causing a healthy appearance in a short time. A pad was placed on the flank, with a bandage round the abdomen, to compress the walls of the cyst, and to facilitate the expulsion of the secretions.

Pus was freely poured out till about the end of fourth week, when the quantity gradually diminished, and by the end of the sixth week had ceased, it being evident that the walls of the cyst had become obliterated by adhesion.

No gas escaped from the cyst after the third day.

The bowels were inactive from the second day, succeeding the operation for twelve days, when they were encouraged to act by water enemas. Considerable quantity of solid fæces came away with some annoyance, after which there was no trouble in this respect.

From the day after the operation her general condition rapidly improved without any material drawback. The vomiting entirely and immediately ceased. She took solid meat on the third day, and every day after, with plentiful supply of other nourishments. At first six glasses of port wine were daily taken, being necessary to keep her from fainting. About a week after the secretion of pus had been completely established, she was able to reduce the stimulants, till at the end of the fifth week she took one or two glasses daily, and some ale. The tongue assumed its natural appearance in about two weeks. The pulse remained small and quick for four weeks.

The peculiar odour of breath ceased about the end of the first week. Urine was passed in large quantities, and pale in colour. She was taken out of bed on a stretcher on tenth day to have the bed made.

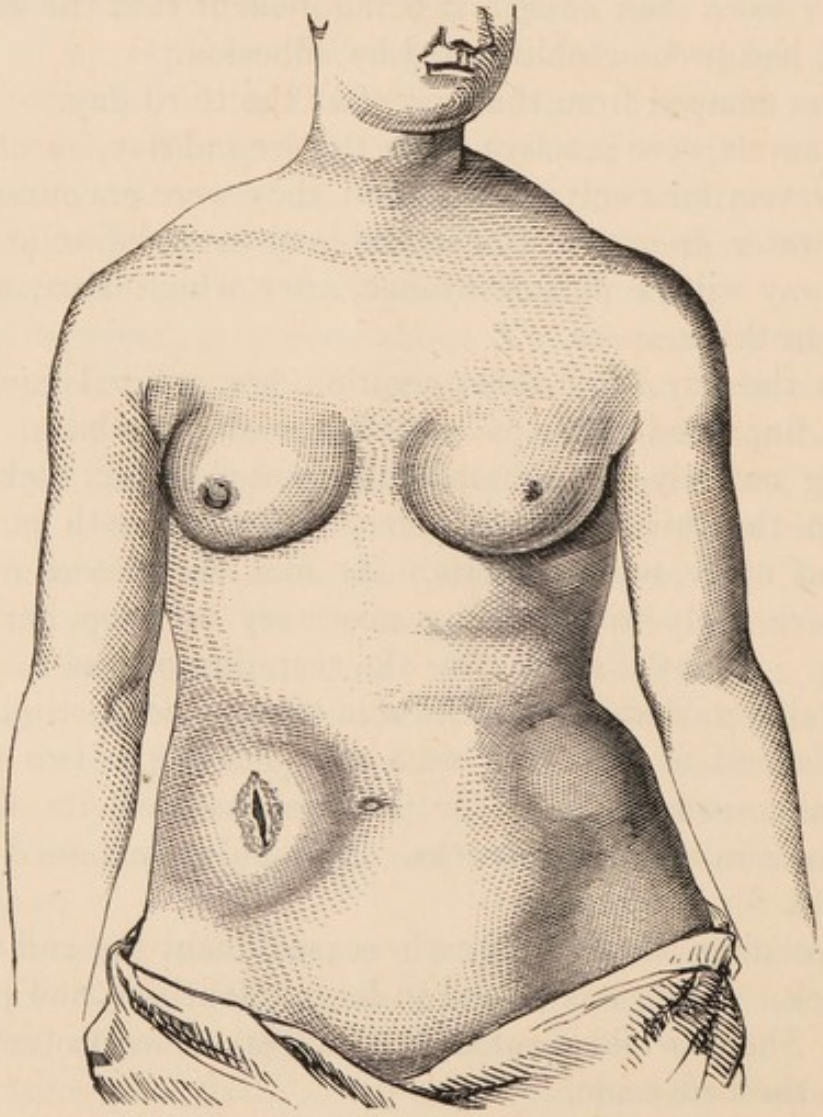
Her spirits were excellent, coupled with extreme nervous susceptibility, which at first could only be controlled by large

doses of morphia, which had to be continued in smaller quantities for some weeks after.

There was, at about three weeks after the operation, some inflammation of the veins of the left leg and some œdema of it, but this soon subsided.

She has now quite regained her natural appearance, and has been out of doors walking. The recovery thus, it may be seen, has been excellent throughout.

The drawings of the fœtus, and the position of the cyst in the abdomen, now handed round, were kindly made for me by Mr. Wood who assisted in the case.



Remarks.—Without occupying the time of the Society with an analysis of the whole case, there is one point to which I should like to call attention.

Whatever may be the doubts of any one as to the propriety of removing the fœtus before its death, in the cases of extra-

uterine pregnancy, I think it will be conceded that where communication has taken place with the intestines so as to cause rapid decomposition of the fœtus and absorption of putrid matter, we ought in every case to make an attempt to save the patient, for it will, I think, be found that generally there is less likelihood that pointing takes place through the parietes, and the patient more quickly sinks under the irritation, than in cases where no communication exists. Under these circumstances it is all important that we should be able to say whether adhesion of the cyst to the abdominal wall has taken place, and if it have, at what spot. We might be inclined at once to say that with this great source of irritation we should certainly expect to find ample adhesion everywhere, and most probably to the parietes. This it might be thought still more likely to be the case after the lapse of a month after the communication. This was certainly the condition in the case just read, but in one of my other cases related in Guy's Hospital Reports[1] it was found that although communication had existed some time, there was but a very limited adhesion of the fœtal membranes to the parietes, and no adventitious cyst around it within a considerable distance of this parietal attachment. To expect recovery after the removal of a putrid fœtus by abdominal section, where the peritoneum was exposed, would be contrary to experience in abdominal surgery. From what I have noticed in the three cases in which I have removed the fœtus by this mode we may probably make tolerably sure of securing the point of adhesion by strict attention to the spot of most severe tenderness on pressure. If we make a small opening first of all at this point we shall generally be safe if we cautiously pass the finger first of all to feel from within for evidence of adhesion, after which the wound can be enlarged. Should we approach the position of any artery of the parietes it is better to run the chance of dividing it than of exposing the peritoneum.

Another point of importance is the size of the opening.

[1] "On two cases of Extra-Uterine Fœtation treated by Abdominal Section," 'Guy's Hospital Reports,' 1862, p. 127.

This, so far as regards the risk of opening the peritoneal cavity, has been considered, but it is important also in regard to the chance of hernia afterwards. This, as is well known after ovarian operations, is a matter not to be ignored, and therefore the smaller the opening we make the better. For this reason it would be well, if the cyst be tolerably strong, rather to remove the fœtus piecemeal, of course carefully, than to attempt to drag it through whole; or to enlarge the wound to a size which may risk the opening the peritoneal cavity. These remarks are of special importance if the fœtus be full grown.

I presume also that it is now admitted that it should be our rule to leave the placenta to come away gradually, and not to attempt to remove it at the time of the operation; its attachment is generally very firm, and where we leave a free opening for discharges and for washing out the cyst, the decomposition of it within is not of such extreme importance as to induce us to chance laceration of the cyst-wall by attempts at removal. This case proves the value of this rule.