VIII. CASE OF FATAL COMPLETE IRREDUCIBLE PROLAPSUS UTERI.

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Kustner, in his article on Displacements of the Uterus in Veit's *Handbuch der Gynäkologie*, says: "It is very seldom that the consequences of prolapse lead to fatal diseases. In general, patients take their prolapse, even when they have completely neglected it, unpunished on into old age without being seriously distressed by it or its complications."

Spiegelberg,[1] however, has put on record and figured a case where a patient died of peritonitis associated with irreducible prolapse, and the following notes of a case are of sufficient interest as illustrative of a condition which was not only impossible to relieve by palliative measures, reduction, or operative interference, but which in itself ultimately proved fatal to the patient.

Mrs B., laundress, aged 42, was admitted to the Buchanan Ward, Royal Infirmary, on 30th September 1904, complaining of falling down of the womb. A fortnight previous to admission, her medical attendant, Dr Orr, had been called in, as she had been suffering from diarrhœa for two weeks, along with

[1] "Medianschnitt durch ein Becken mit Scheiden-Gebärmutter-Vorfall," *Arch. für Gynaekologie*, Berlin, 1878.

fever varying from 101·6° to 103° F., and a somewhat slow pulse. Typhoid fever being at first suspected, the Widal test was applied, but was found to be negative.

After the first week, Dr Orr's attention was directed by the patient to a swelling protruding from the vulva, which he diagnosed as prolapse of the womb, which was found impossible to reduce. He applied an ice bag, and three days later, in consultation with Dr J. W. Ballantyne, reduction was again attempted under chloroform, without result. In consequence, she was admitted into hospital as above stated.

General History.—Two years ago, patient began to experience pain in the region of the womb. The pains were of a down-bearing character and came on at intervals, especially after a hard day's work. No difficulty was experienced at this time in micturition, but patient noticed that if her bowels were constipated her symptoms were worse. Eight months later she first noticed something protruding slightly from the vaginal orifice. She had no idea at the time what was wrong, and did not seek medical advice. The protrusion became more and more evident, in spite of the patient endeavouring to prevent it by wearing a support. After a further interval of eight months the womb was observed by her to be entirely projecting from the vaginal orifice, and, once out, she found that it was impossible to return it. At first, walking was not much interfered with, but sitting was found to be uncomfortable, and she always felt better when moving about. At this time difficulty was experienced in micturition, accompanied with pain before and during the act. The bowels were not affected. From the beginning of the trouble two years ago the periods became affected, being increased both in regard to quantity and duration. As the womb became more and more established in its new position, she began to experience impediment in her movements, and, in addition, pain of a severe dragging nature. Since pro-

trusion, the mass was noticed to be inflamed, with a tendency to enlargement and ulceration. The patient took to bed fourteen days before admission, as she then experienced diarrhœa, with slight vomiting and irregular fever. Dr Orr was sent for, but the patient thought so little of her condition that she did not inform him about the tumour mass until a week later, previous to which, and in regard to the prevailing symptoms, she was being kept under observation as a possible case of typhoid fever.

Previous History of Patient.—Ten years ago she had a child; the labour was severe, and forceps were employed. The puerperium was normal, but she did not nurse her child. The menstrual type and habit were normal up till two years ago, and there was no history of any miscarriage. Patient had three brothers, two of whom died of phthisis.

Physical Examination.

The abdomen on inspection presented no prominent irregularity, umbilicus retracted, linea nigra and striæ were well marked.

On deep palpation, which at any point over the abdomen elicited pain more or less severe, a hard mass, rough in outline, about the size of two fists and slightly mobile, was felt stretching across about the level and extending for some distance below the umbilicus. On moving this mass the whole intestines apparently moved along with it. Projecting from the vaginal orifice a large tumour was seen, pyramidal in shape, 5½ inches in length and 4 inches in breadth. and constricted at the vulva. The os externum was distinctly visible at the lower end of the tumour, with the lips greatly hypertrophied, everted, and extensively eroded. The surface of the tumour was dark red in colour and covered with glairy mucus at its lower extremity, and presented on the surface the appearance as of an epidermic structure, so often assumed in cases of long-

standing prolapse. Numerous shallow ulcers of varying shape and size were noted at different points of the mass besides the general excoriation of the lips. On either side, below the labia majora, beginning at the neck of the tumour, was a long narrow strip of ulceration corresponding to points of contact with the inner surface of the thighs. The everted vaginal wall was thickened and œdematous, and at points presented a macerated appearance with loss of tissue.

The whole mass was extremely sensitive to manipulation, and with a finger in the rectum the fundus of the enlarged uterus could be felt in the back part of the swelling. A catheter passed into the bladder revealed it lying in the front part of the herniated mass entirely below the level of the external pudenda, and there were also to be felt fluctuating spots, the nature of which it was impossible to divine.

Treatment.

With a view to reducing the œdema and favouring as far as possible the reduction of the mass, the patient was placed in the recumbent posture, with the foot of the bed elevated and pillow removed. The tumour mass, surrounded with boric lint, was slung from both thighs by means of a domette bandage. Owing to the frequent passage of water, almost every hour, the dressing required constant renewal, thus rendering it difficult to keep the enveloped part thoroughly clean and dry.

The possibility of the hard mass in the abdomen being due to the lodgment of scybalous masses, was removed by the administration of castor oil and enemata, but without any appreciable diminution.

The patient was subject to attacks of vomiting at intervals, which was relieved by means of bismuth and hydrocyanic acid, and the suspicion was entertained that malignant degeneration was developing in the peritoneal cavity. From day to day the patient showed increasing signs of restlessness, and natural sleep

was impossible. The temperature continued to swing from normal in the morning to a little over 101° F. in the evening, and the pulse-rate accelerated from 92 to 140. Within the last twenty-four hours mental symptoms became prominent, and she died eighteen days after admission.

Pathological Report.

Dr Stuart M'Donald made a post-mortem examination of the case, and has kindly given me the following notes:—

External Examination.—Rigor, general emaciation, complete prolapse of uterus, which shows much superficial excoriation.

Thorax.—Lungs: some chronic adhesions found over both; both are also slightly emphysematous, more especially the right. On section both are somewhat dry and tough, with exception of bases, which show some hypostatic congestion. No pneumonia or tuberculosis present.

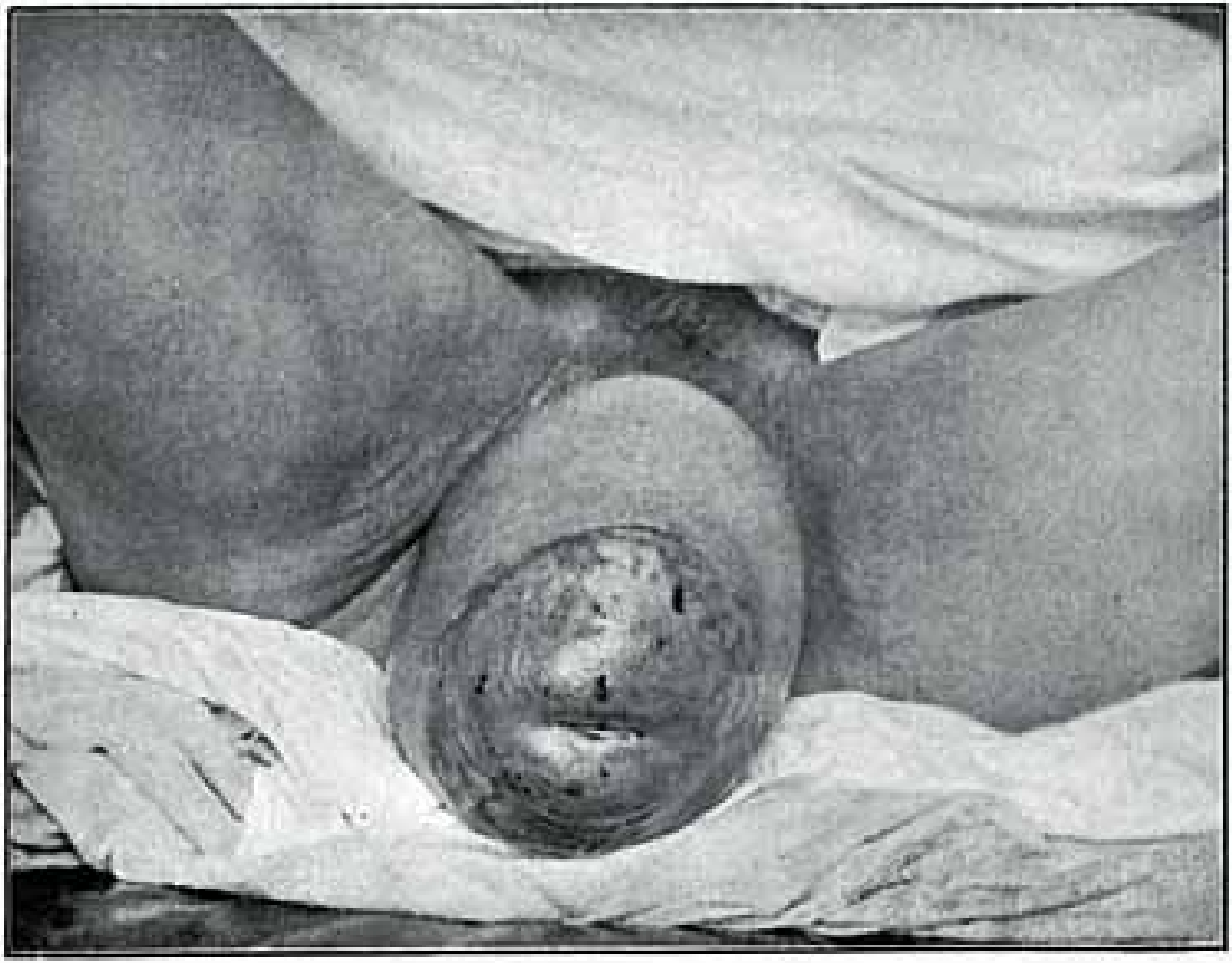
Heart.—Weight, nine ounces. Surface shows nothing abnormal. Right auricle and ventricle slightly dilated. Valves and orifices show nothing abnormal beyond some degenerative thickening of anterior cusp of the mitral. The myocardium shows some pigmentary degeneration and a slight degree of diffuse fatty degeneration.

Abdomen.—Dense chronic general peritonitis; intestines and omentum firmly adherent to abdominal wall. Condition extends down into pelvis, and is even more marked there. The matting is so intense that the reduction of the prolapse is a physical impossibility.

The spleen shows chronic perisplenitis, and on section there is some congestion and pigmentary change.

The liver shows chronic perihepatitis and diffuse fatty change. Gall-bladder shows nothing abnormal.

The kidneys are pale, but otherwise show nothing specially



General view of Prolapse taken during Life.

abnormal to the naked eye. There is no dilatation of the pelvis, and there is only very slight dilatation of the ureters.

The dense adhesions of the coils of intestine to one another made dissection *in situ* impossible, and the contents of the lower part of the abdomen and pelvis were removed entire, together with the prolapse and external genitalia. On examination, there was found between the umbilicus and pubis a collection of pus evidently communicating with the deeper part of the pelvis. Below the umbilicus was a dense hard mass consisting of adherent coils and thickened, chronically inflamed mesentery. The adhesions and kinking of the coils had led to considerable obstruction of the lumen at many places. In dissection the bowel was torn at several places, but no ante-mortem rupture could be found, and in the intestine, as far as could be examined, no ulceration was discovered.

The entire mass was hardened in formalin, and the following description is taken from the prepared specimen. The mass projecting from the vulva measures about 5½ inches vertically; it is flattened laterally, measuring about 4½ inches antero-posteriorly by 3½ inches laterally. The surface of the mass shows superficial excoriation, with irregular islets of thickened epithelium. A median sagittal section shows the relation of parts with numbered index. (See Plate.) In the right half posteriorly the rectum and anus are seen; advancing forwards, the smooth-lined pouch of Douglas is observed; about 1½ inches above the lower limit of the pouch of Douglas is the outer aspect of the fundus. The uterus is not inverted, and the uterine cavity is well seen. In front of the uterus the utero-vesical pouch filled with pus is next observed; the lower limit is 2¾ inches below the level of the fundus, and the space at the lower part is about 1 inch across. From this space a track of suppuration can be traced upwards among the coils of intestine for about 8 inches. At the upper end an abscess cavity with roughened walls is well seen: this is the collection that was opened at the post-mortem.

About ½ inch above the fundus there is a pus-containing pouch of peritoneum extending downwards behind and to the left of the pouch of Douglas. This opens into the utero-vesical collection. The broad ligaments and tubes are twisted, and their relations are difficult to make out. Both are found in the left half of the specimen, but apparently the left ovary and tube lie still in the pelvis above and behind the rectum, while the right lies outside the vulva in the prolongation from the utero-vesical pouch mentioned above.

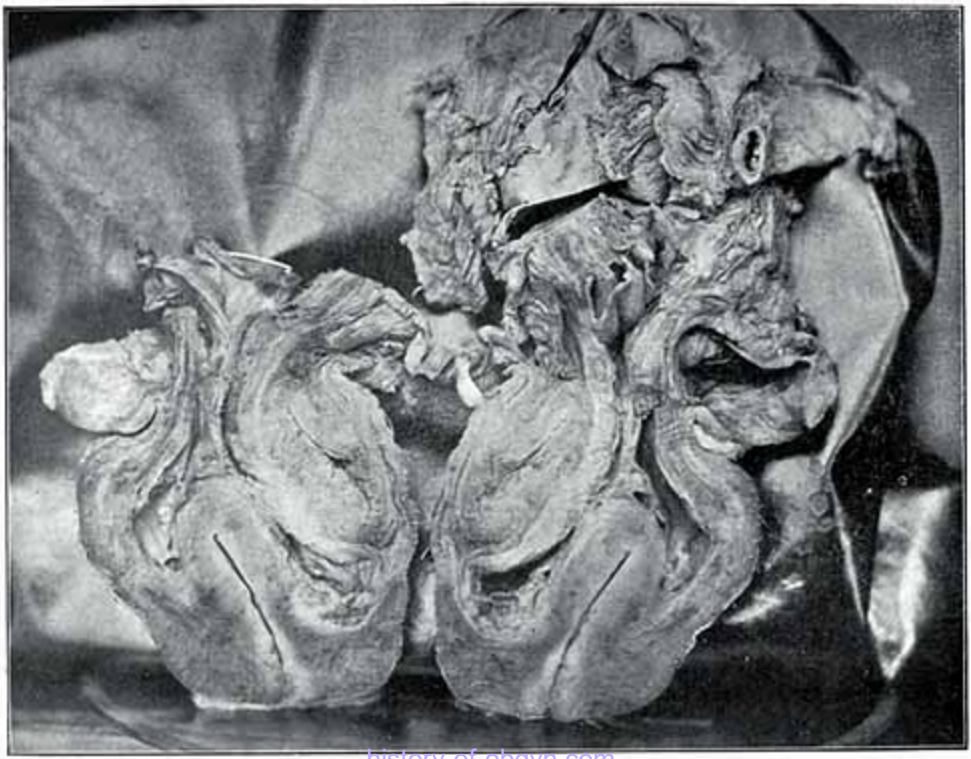
Continuing the description of the right half of the specimen, the bladder, also entirely outside the vulva, with enormously thickened walls and almost obliterated lumen, is next observed. A number of small calculi were also found in the bladder. The urethra is also well seen, and was quite patent. A special feature is the everted and greatly thickened vaginal walls. High up among the intestinal coils, the masses of chronically inflamed mesentery and mesenteric glands are well seen. Microscopical examination of those masses shows a simple chronic inflammatory condition without trace of tubercle or malignant disease.

General Remarks.

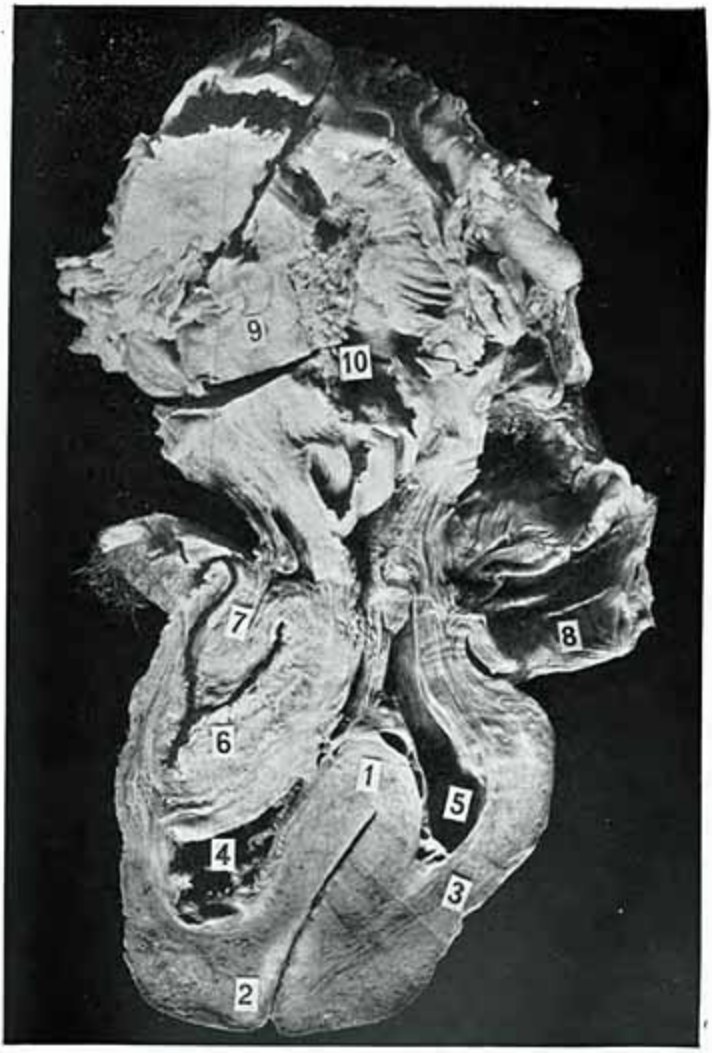
The case is remarkable from the apparently slight inconvenience caused to the patient, who up to a fortnight before her admission into hospital was going about her ordinary work.

There can be little doubt that the condition was of gradual occurrence. As to the cause of it, we note that the patient's one labour was a severe one, necessitating delivery by forceps, and that involution of the uterus would be retarded somewhat in the absence of lactation. Further, her daily occupation must not be overlooked as a probable factor in the causation.

Various conditions have been described as rendering reduction of a prolapse mass impossible, such as fibroid tumour in



Section of tumour mass made post-mortem, showing right and left halves.



RIGHT HALF OF TUMOUR (half the natural size). By RICHARD MUIR.

1, Fundus uteri; 2, lower end of cervical canal with everted thickened lips; 3, hypertrophied vaginal wall; 4, utero-vesical pouch with flaky deposits of lymph; 5, pouch of Douglas; 6, wall of bladder; 7, urethra, seen to the left, displaced upwards; 8, anal canal; 9, inflammatory mass in mesentery; 10, collection of pus among coils of small intestine in direct communication with 4; the upper limit is very about 1 inch higher.

the wall of the uterus, the presence of ovarian tumour, stone or stones in the bladder of considerable size, various degrees of peritonitic adhesions, and it must be under the head of this last category that the above-recorded case is included.

How the abscess cavity, discovered quite accidentally post-mortem, came about, must be a matter of pure conjecture.

It is not clear how the septic processes to which the patient ultimately succumbed originated, but it is obvious that the long-standing displacement had become associated with peritonitic adhesions among the dislocated viscera, and from the bowels or eroded surfaces of the tumour septic organisms may readily have found their way into the tissues and on to the peritoneal cavity, where the pus accumulation had taken place. The spread of the septic process among the intestinal coils had no doubt already taken place before the patient came under observation.

The displacement of the bladder brought about by the prolapse is of considerable interest. In the normal collapsed condition the cavity of the bladder combined with the canal of the urethra is represented by the letter Y, of which the two upper limbs represent the bladder and the lower limb the urethra. The Plate shows very well the displacement upwards of the lower limb of the Y, *i.e.*, the urethral canal, with corresponding change of position of the anterior and posterior walls of the bladder represented by the other two limbs.

Dr James Ritchie thanked Dr Barbour Simpson for his clear description of this interesting case.

Professor Simpson remarked that it was seldom a case of irreducible displacement occurred.