

A CASE OF INTRAPERITONEAL GESTATION AT TERM.
OPERATION AFTER DEATH OF FETUS. RECOVERY.¹

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(With three illustrations.)

ON February 16th, 1897, I saw, in consultation with Dr. G. R. Feil, a woman who had then gone beyond term about two weeks, and had gradually ceased feeling "life" after having suffered from false pains between February 1st and 3d. My advice was sought, not on account of any suffering, but because husband and wife felt uneasy about the probable death of the child, and anxious to have terminated the pregnancy now overdue. Her physician had only recently been engaged to attend her, knew nothing of her previous history, and had no cause to suspect anything abnormal. He examined her in labor, heard the fetal heart very distinctly, found a slightly tinged discharge, the cervix soft, the os rigid and not dilatable, the pains short, sharp, exasperating. The pains proving ineffectual, he gave an anodyne for relief, as he regarded the attack merely as a false alarm. By degrees the pains ceased and did not return.

When seen by me the patient, an undersized brunette, of healthy family, was in the kitchen attending to her household duties. She was 33 years old; married eight years; 11 para, the last child born five years ago; no abortions. Previous to her pregnancy her health had been good, her menses regular, the last period April 23d, 1896. She failed to "come round" in May, which so upset her plans that she consulted a "doctor," who dilated the womb on June 13th. The attempted abortion caused the loss of a few drops of blood, but was followed by no further consequences. On June 23d she was lying on the sofa. Suddenly she was seized with a most violent pain in the abdomen, fell to the floor, and fainted. When she recovered consciousness she could not get up, but was carried to bed, and was confined for two weeks with supposed perito-

¹ Read before the Ohio State Medical Society, at Cleveland, May 20th, 1897.

nitis. She remained weak all through the summer and fall. She did not feel life until the latter part of October, though she was told she was pregnant while on a visit to Buffalo late in August. She has never felt much motion. Since the spurious labor she has positively diminished in size.

The contour and size of the abdomen correspond to an eight-months gestation. The enlargement consists of a large, smooth, round tumor filling the abdomen, except low down in the left hypogastrium where it crowds a smaller, harder tumor to be felt from the point of contact above the pubes to the extreme left in the iliac fossa. Fetal parts cannot be made out. There is no fluctuation. There are no movements, contractions, or fetal heart sounds. The cervix is soft; the external os admits the end of the finger, but the internal os is dense, will not admit of dilatation by the finger. A careful bimanual (repeated on different days) enables me to recognize the smaller tumor as the uterus, elongated and pushed to the extreme left by the larger tumor. The posterior vaginal vault is slightly bulged down, convex, filled with a doughy, tender, immovable mass.

The diagnosis of ectopic pregnancy originating in the right tube, and of a dead fetus, was foreshadowed by the history and confirmed by the physical examination. It was decided to watch the patient and await indications for interference. On the eve of February 20th Dr. Feil was called. The woman had felt chilly all day and had severe pain in the abdomen. Her temperature was 100.5° , pulse 90; abdomen quite tender, especially about the umbilicus. She was removed to the Cleveland General Hospital the following morning. The evening temperature was again 100.5° , pulse 98; tenderness and pain constant. Operation set for the 22d.

Operation February 22d. Present, Drs. Feil, N. Stone, Scott, Towslee, Bernstein, and several private students. Anesthetic, chloroform. After the patient was anesthetized the sound was introduced into the uterus. It entered five inches to the fundus in the direction of the long axis of the smaller tumor. The median incision, from the umbilicus downward, was afterward extended upward about three inches. The parietal peritoneum was much thickened and dark in color, not adherent to visceral contents. The gestation sac now presented. Across the upper part of the sac, which reached nearly to the liver, lay the infolded omentum. The latter was attached to the sac by recent adhesions. Upon gently loosening

these the skin of the fetus became visible through the opening in the sac that had been plugged by the omentum. The loops of intestine surrounding the opening in the sac were intensely red. The opening was extended downward by an incision through the sac wall, disclosing the somewhat macerated female fetus. The breech presented, the back of the child to the abdomen of the mother. The child was delivered, the funis clamped and cut. There was not a drop of amniotic fluid either in the sac or in the abdominal cavity. The amnion formed the inner lining of the sac. The boundaries of the gestation sac were now examined. It crowded the elongated uterus far to the left. It extended from the inner border of the left broad ligament, occupied the entire right pelvis, and enclosed the lower abdomen, forming a dome over the pelvic cavity. Above it was covered by adherent intestines. The lower anterior wall was formed of uterus and broad ligament. The sac wall, except where the posterior surface of the uterus and of the broad ligament complemented it, was composed of organized lymph, its thinner portions readily breaking down. The intestinal adhesions were now relieved with the intention of extirpating the entire sac. There was no difficulty until the sigmoid flexure was reached. This was so intimately connected that to continue would be to risk gangrene of the gut. Extirpation was therefore abandoned. Behind and below the sac, adherent to the bottom of the recto-vaginal pouch, was a mass as large as an orange, which on enucleation proved to be an organized blood clot. The placenta was attached within the anterior portion of the sac to the right margin and right posterior surface of the uterus. The detachment of the placenta was begun at the bottom of the sac and was quickly accomplished. Tufts of placental tissue and shreds of membrane were left in the sac. The hemorrhage was not at first severe and was controlled by a firm pack of hot gauze sponges. While stitching the sac wall to the abdominal incision there was noticed a rapid bleeding through the pack. The sac was emptied and repacked, but the bleeding went furiously on. The left broad ligament was clamped. The tissues to the right of the sac were also clamped. The sac was repacked. The hemorrhage was now under control. Meanwhile my assistants had lowered the head of the blanched and all but pulseless patient and made an intravenous transfusion of eight ounces of normal salt solution. The left ovarian artery was now ligated. The right ovarian and the uterines could not be

reached. The clamps were removed, the edges of the sac were stitched to the parietal incision, and, as there was no bleeding, the gauze packs were left undisturbed in the gestation sac.



FIG. 1.—Skiagraph of head of fetus.

The vagina was firmly tamponed and a T-bandage attached to the abdominal binder. The operation had lasted seventy-five minutes. The following are the essential features of the post-operative history :

February 23d: Patient has rallied nicely from the shock. February 24th: Symptoms of sepsis; pulse 130 to 140; abdomen much distended; removed packing; discharge very offensive. February 25th: Had a poor night; restless; pulse 144; vomited once a dark fluid; removed shreds of membrane and small pieces of placenta; discharge from sac still very offensive. February 26th: Pulse 126; abdomen still much distended, but wound not offensive.

March 7th: Has been steadily improving, but temperature



FIG. 2.—Skiagraph of lower half of fetus.

varies from 100° to 101°. Removed a gauze sponge from the bottom of the sac that had been overlooked at the time the others were removed. From this time on convalescence was uneventful. She was kept in bed seven weeks to avoid a strain on ventral cicatrix, and left the hospital in excellent condition April 18th. On May 6th she menstruated. There was no pain. The menses were scant and lasted two days.

The fetus was twenty inches long and weighed six and a half pounds. Its surface was macerated, the epidermis peeling off in large flakes. The bones of the skull were loose and flabby;

the cranial contents were soft, fluctuating, as is usual in a macerated fetus. There was no deformity. An X-ray was taken by Dr. Scott.

Cases of extrauterine pregnancy gone to term are not plentiful. With better training in early diagnosis, and with early removal of the products of gestation, such cases will become less frequent than at present. "During the hurry and dread of a critical operation," as Parry graphically expresses it, some of the details of the case here recorded were not noted, much to our regret. Sufficient data are at hand, however, to warrant the conclusion that our case is one of very rare occurrence and of unusual interest.



FIG. 3.—Skiagraph of arm of fetus.

The attempted abortion deserves but a passing notice. It had no bearing on the subsequent history. It is evident that the right tube ruptured when the patient was two months pregnant. That the rupture was intraperitoneal is proven by the organized blood clot adherent in the recto-vaginal pouch. Not until after spurious labor were there any symptoms of secondary rupture. "Cases of primary intraperitoneal rupture are almost uniformly fatal, either from hemorrhage or subsequent suppuration of the sac and peritonitis."¹ In our case the intraperitoneal hemorrhage did not prove fatal nor did suppuration take place. The uninjured ovum, containing a living fetus, was partly or wholly expelled from the ruptured tube, leaving

¹ Tait, "Diseases of Women and Abdominal Surgery," vol. i., p. 443.

the placenta in the tube. The ovum continued its development within the abdomen, surrounded by exudate and blood serum. The gestation sac thus formed attachments to the blood clot anchored below and to the intestines above, while the placenta continued its growth close to the uterus. The fetal membranes and organized lymph formed the only envelope of the fetus above the pelvic brim. After the spurious labor the fetus died and the amniotic fluid was absorbed; the patient herself noted her diminution in size. There was a final rupture of the upper anterior sac wall a few days previous to operation, causing a localized peritonitis which gave the direct indication for interference.

According to Webster's¹ classification our case is one of "tubo-peritoneal gestation, in which escape of the fetus in the membranes takes place into the peritoneal cavity, the placenta remaining in the tube and development continuing." Webster further says: "The first undoubted case of such a form of ectopic gestation was described by me in a monograph published in 1892. Several of the older writers, and also recent ones—*e.g.*, Küster, Werth, and Berry Hart—thought this form possible, while others denied its possibility, believing that rupture of the tube into the peritoneal cavity meant death to the mother unless she were operated on."

Our case sustains the broad view of Tait as against the narrow opinion of Bland Sutton. The old theory of abdominal pregnancy, that it is caused by the development of an impregnated ovum dropped into the peritoneal cavity, has been generally abandoned. It is now believed that "*all forms of extra-uterine gestation pass their primary stages in the Fallopian tube.*"² Tait's present explanation of the abdominal variety under consideration is to the effect that "what have been called abdominal pregnancies are clearly exceptional cases where primary tubal rupture at the end of the third month has not proved fatal; where the extended placenta has made for itself visceral attachments wherever it has touched; or where secondary rupture of a broad-ligament cyst has converted an extraperitoneal ectopic gestation into one within the peritoneal cavity."³ Sutton⁴ dissents as follows: "This view [of Tait] I cannot bring myself to accept. I am of opinion that these

¹ "Ectopic Pregnancy," p. 53.

² J. Bland Sutton, "Surgical Diseases of the Ovaries and Fallopian Tubes," p. 844.

³ "Lectures on Ectopic Gestation," 1888, p. 13. ⁴ Op. cit., p. 845.

so-called abdominal pregnancies are primarily tubal; gradually the tube opens out into the broad ligament, and as it progresses to term the walls of the gestation sac rupture and the fetus escapes into the peritoneal cavity, as in the remarkable case recorded by Jessop." In other words, Sutton believes that all such pregnancies have continued their development within the broad ligament until late in the gestation, when rupture of the broad ligament allowed the escape of the fetus into the abdominal cavity.

The cases of Jessop, Champneys, and Taylor, cited by Sutton in support of his views, differ in this essential from our own, that the fetus lay free among the intestines in the abdominal cavity without any membranous envelope, the fetus having but recently escaped from the gestation sac. The gestation sac in our case was not broad ligament, but the membranes of the ovum fortified by organized exudate. The fetus was not free among the intestines, but was enclosed within the gestation sac.

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