

DR. M. ROSENBERG reported a case of **Ectopic Gestation Following Modified Pomeroy Sterilization.**

Patient E. C., white, aged thirty-four years, was admitted to my service at The Jewish Hospital, on July 23, 1930, with a history of rheumatic endocarditis of several years' duration complicated by a five weeks' pregnancy, last menstrual period being June 13, 1930. Patient has been married sixteen years and has two children, the youngest six years old. The first child was delivered by instrument. The patient presented a mitral systolic murmur and tender joints throughout the body. The pelvic floor was relaxed, a slight cystocele, was present, the uterus anteroposed, somewhat enlarged and soft, the adnexa were negative. Because of the history of rheumatic endocarditis a therapeutic abortion and sterilization was decided upon.

On July 24, 1930, a dilatation and curettage was performed, followed by an anterior colporrhaphy through which was done a modified Pomeroy sterilization; that is, ligation and resection of a large loop of the cornual end of the tubes followed by electrocauterization of the severed ends of the tubes. Patient made an uneventful recovery and was discharged on August 5, 1930.

On December 5, 1930, patient was readmitted to Dr. Schwartz's service at The Jewish Hospital with the following history: Patient had two regular periods in August and September, following operation. The October period was delayed a few days so that patient resorted to medication, and began bleeding on November 10, 1930. The bleeding lasted about three days. However, on November 25, she began bleeding again, and on November 29 she experienced a severe sharp pain in the left lower quadrant, the pain being constant in character and associated with spotting and painful micturition.

Examination revealed marked abdominal tenderness with no rigidity in the left lower quadrant.

Vaginal examination revealed a firm parous pelvic floor with a well-healed firm anterior wall, a parous soft cervix that was tender on motion; the uterus slightly enlarged, was displaced anteriorly and to the right by a very tender small cystic mass in the left fornix.

Diagnosis of a left tubal pregnancy was made.

On December 6, 1930, a postvaginal section was performed, and free blood was found in the peritoneal cavity. This was followed by an immediate laparotomy. A median infraumbilical abdominal incision was made. The abdominal cavity was filled with a moderate amount of blood and blood clots. The omentum was found stretched and intimately adherent to both cornual ends of the uterus at the site of the previous resection of the tubes. The right tube was normal and separated from the uterus at its cornual end. The left tube which was the seat of an ectopic gestation was distended at its proximal end which was smooth and distinctly separated from the cornual end of the uterus. The two round ligaments were intact.

The omentum was freed from its adhesions and ligated. The left tube was freed from its adhesions, and a left salpingectomy was performed. The abdomen was closed in layers.

The tube was 7 cm. long, about two-thirds distended by blood clot 2 cm. in diameter, attached to the wall of the tube.

Microscopically, the tube was the seat of a chronic inflammatory process, contents consisting of blood clot and chorionic villi.

From the above case and those others reported in the literature it is evident that tubal ligation with resection is not an efficient measure to prevent conception.