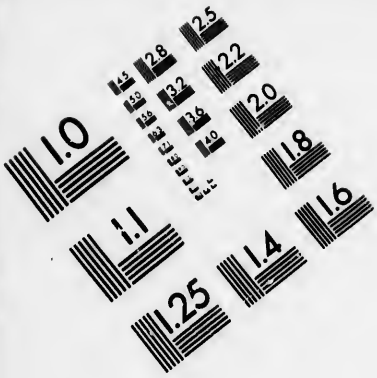



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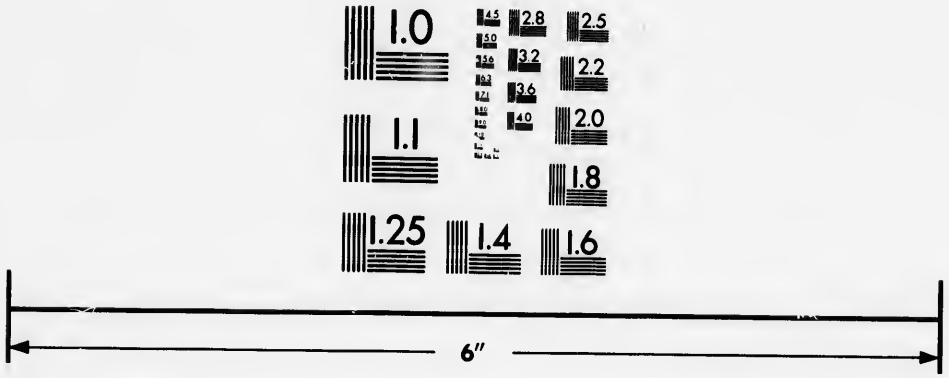


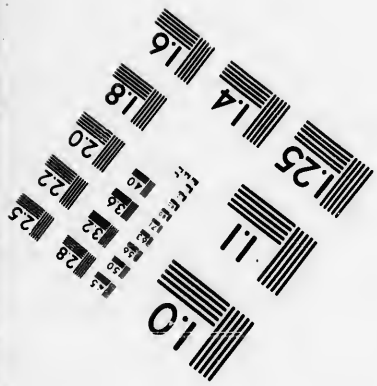


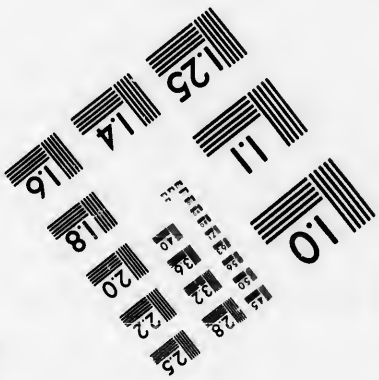


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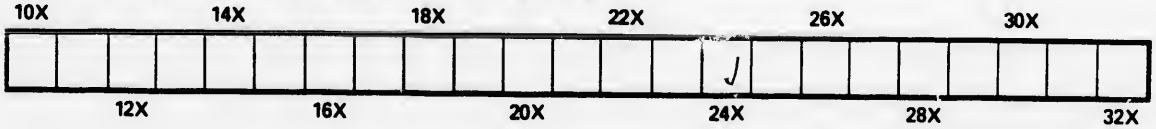


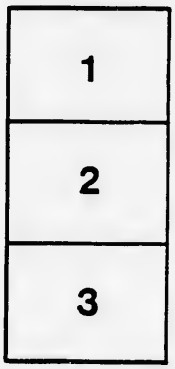


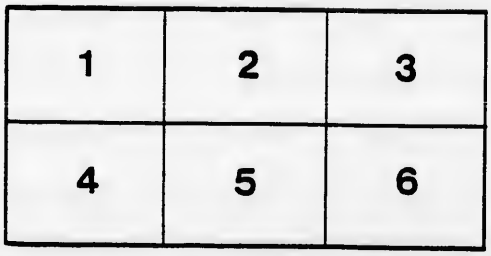

With the author's compliments.

# THREE CASES OF PELVIC HÆMATOMA.

BY

WILLIAM GARDNER, M.D.,

Professor of Gynæcology in McGill University; Gynæcologist to the Royal Victoria Hospital; Consulting Gynæcologist to the Montreal General Hospital.

THE PATHOLOGICAL REPORTS BY C. F. MARTIN, M.D.

Assistant Physician to the Royal Victoria Hospital; Lecturer on Pathology in McGill University.

(*Reprinted from the Montreal Medical Journal, January*, 1897.)

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The association of pelvic hæmatocele with cancer and tuberculosis of the genital organs of women must be exceedingly rare. In none of the recent works on gynæcology which I have examined is any mention made of it. This statement applies to the classical paper of Whitridge Williams on genital tuberculosis, the chapter on the same subject in the third edition of Pozzi's magnificent work on gynæcology just published (1897), and that of Sir William Priestley in Clifford Abbott and Playfair's system of gynæcology (1896). The same remark applies to cancer of the uterine appendages as treated in each of the works mentioned. This is certainly remarkable, especially as regards tuberculosis now known to be so frequent a disease of the tubes and ovaries, and to which so much attention has been devoted by many observers in recent years. That pelvic hæmatocele may be associated with these diseases is proved beyond a doubt by the two cases I am about to describe. They are unique in my experience. Their exact relation as regards cause and effect is not so certain. The necessary nutritive and vascular changes may have preceded or co-existed with the cancer or tuberculosis, but may not have been the result of these marked processes. What we know of these diseases as they affect other organs or structures of the human body is surely a cause for wonder that effusion of blood is not frequently caused by the much more frequent tuberculosis of the ovaries, and especially the

Fallopian tubes. By most authors and operators pelvic hæmatocele is in the enormous majority of all cases held to be due to ruptured ectopic gestation. The evidence on which this opinion is based does not always bear close scrutiny. The necessary evidence of the presence of a fœtus or chorionic villi or other decidual elements is not always to be had even when carefully sought for.

*Extra-uterine Pregnancy.*—Mrs. S., aged 35, was seen in consultation with her ordinary medical attendant, Dr. W. F. Hamilton. She has been married twelve years and is the mother of six children to full term. She had a miscarriage in January, 1896, for which an anæsthetic was given to remove some portion of the products of conception. In May she had regained her health and continued well till August. The last normal menstrual period occurred about the 5th of August, there was no return till the 10th of September. The discharge was then scanty and of short duration. From this time on till the time of operation on the 11th of November, there were discharges of blood at irregular short intervals, there were also paroxysms of pelvic pain, but no syncope or collapse. During the last two weeks previous to operation vomiting occurred several times, but at no time was there any elevation of temperature. When I first saw her about the middle of October, the uterus was somewhat enlarged and soft, and to its left and adherent to it there lay an elastic fixed mass; this rather rapidly increased in size during the three weeks I occasionally saw her before operation. At the time of operation there was a distinct abdominal tumour. The patient was admitted to my private hospital on the 11th of November.

*Operation.*—The uterus was dilated sufficiently to admit the finger to the fundus and the cavity found to be empty except for a general lining with decidual membrane; it measured five inches in depth.

*Abdominal Section.*—No free blood or fluid of any kind in the cavity; a livid tumour-like swelling adherent to the whole of the pelvic walls and floor, the adhesions not very dense. During the process of separation a large quantity of almost black fluid and clotted blood escaped. At the bottom of the pelvis lay the fœtus and placenta, apparently detached, but lying in the sac described; part of the wall of the sac was formed by the posterior wall of the uterus. After the removal of the fœtus and placenta the rest of the sac was easily separated and brought through the abdominal incision, when it could be as easily ligated as an ordinary empty ovarian cyst. No bleeding of any consequence followed the separation of the sac, so that the abdomen could be closed without drainage. Recovery has been absolutely uneventful.

The specimens presented, illustrate one of the most unusual varieties of ectopic gestation, and clearly show from a carefnl study of the relation of the parts how intimately associated may be the ovary and tube in ectopic gestation, the tube being the primary site of the event, while the ovary is to all intents and purposes purely passive.

The material was sent me by Prof. Wm. Gardner on November 11th, 1896, and on gross examination was seen to consist of fonr distinct portions:

1. A male fœtus 12.2 cm. long with 3 cm. of cord attached.

2. A placenta 15 x 6 x 2 cm. in dimensions with a portion of cord 10 cm. long adherent to it.

3. A containing sac of about 12 cm. in greatest diameter. Its wall was of varying thickness, densest at its outer extremity (*i.e.*, the part furthest from the uterus) where there was seen a flattened out mass of tissue of 1½ cm. in thickness, and containing a few narrow, elongated spaces filled with clear, thin fluid (probably compressed ovarian cyst). This mass was intimately associated with the rest of the wall, gradually becoming thinner at its peripheral portions where it passed imperceptibly into the rest of the wall of the sac. Mieroscopic sections showed abundant evidence of its ovarian nature.

Elsewhere the sac was thinner; in some places quite translucent, in others moderately dense and thick. The Fallopian tube was seen coursing for several cm. along the superior portion of the sac, and terminating abruptly in the sac itself as a sudden dilatation, evidently the site of the ectopic gestation.

The inner lining of the sac was in some parts smooth and glistening, where presumably the amnion still remained, in other parts it was rough and ragged from the presence of placental remains and blood clots, all easily detached.

Round about the sac there was evidence of some adhesions with chronic inflammatory fibrosis and local thickenings of the peritoneum.

*Microscopic Sections* were made through eight different portions of the sac wall, and through two portions of the overlying Fallopian tube.

In the first place. specimens were examined from the outer thick mass of tissue suspected to be ovarian, and the condition revealed was as follows: An outer layer of peritoneum with unusual proliferation of the endothelium was seen to cover tissue, undoubtedly ovarian in nature inasmuch as a graafian follicle was found. The ovary itself was, to a large extent, markedly fibroid. Advaneing further inwards, in the same specimens, towards the inner wall of the sac, one could distinctly see the mneosa of the Fallopian tube with great proliferation

of the epithelium and numerous fimbriæ projecting on all sides. Between the tube itself and the superimposed ovary no peritoneal coat could be found, the prolonged stretching, with its accompanying hyperplasia of connective tissue, evidently obliterating all such distinctions. The ovary then, as these sections clearly showed, was flattened out upon the sacculated tube, and helped to form a part of the wall of the sac, but its participation was obviously purely passive, and the condition cannot, by any means, be regarded as a true ovarian pregnancy.

Sections from the smoother, thinned-out portions of the sac showed no special features of interest. Those specimens, however, which included the placental remains showed the usual appearances of the villi, with the blood sinuses, decidual cells, hemorrhages and what has been regarded by Hubrecht, Webster and others, as remains of fœtal epiblast. These cells or collections of cells are massed together, their nuclei staining deeply, as in the case of all embryonic tissue, and their protoplasm absorbing a diffuse eosine stain. They occupy what seem to be indifferent sites in various portions of the placental tissue.

The case then is of interest as showing how easily one may conclude the presence of an ovarian pregnancy, a condition which has been time and again denied, and certainly never been absolutely proven. While ectopic gestation is thought by many to occur primarily not only in the tubes and the ovary, but also on the abdominal peritoneum, the question seems recently to have been more fully studied by Webster, who bases his views on a variety of different methods of examination of a large quantity of material. By means of careful dissection, examination of gross frozen sections and microscopical specimens, he was enabled to show that many cases previously regarded as abdominal or ovarian were really after all but modifications of the tubal form; cases that might under ordinary conditions have been described as truly ovarian in origin were thus shown to be after all merely one or other form of tubal pregnancy, and he is led to consider that ovarian does not exist. Hence, he classifies all ectopic gestation cases under the three simple headings of ampullar, interstitial and infundibular, our own case being included in the last of these three varieties.

It has been granted by most authorities that the ordinary uterine and tubal mucosæ play, but a very minor rôle in the occurrence of pregnancy, and that the subepithelial connective tissue is that upon which the true fertilization occurs; it is for this reason that Orth and many other European authorities still believe in the possible occurrence of an abdominal pregnancy, arguing that the peritoneum itself contains tissue quite analogous to that beneath the uterine mucous membrane

Were there nothing further required to induce this pregnancy there would be no reason for supposing it to occur almost anywhere in the peritoneal cavity, but Webster has shown that there is good reason for believing that some special cellular action must probably occur to induce the process of fecundation. He argues that wherever pregnancy occurs a genetic decidual membrane forms, associated probably in some way with nerve influence, and he further urges that this can take place only along the parts which take their origin from the Mullerian ducts. Hence ovarian and abdominal pregnancies would be impossible, and no one has yet proved a very early ovarian pregnancy to exist.

That some nervous influence is associated with the condition would seem to be true from the discovery made by him in a case of ectopic gestation where the nonparturient tube had likewise a definite decidua upon its inner surface.

Some months ago I had occasion to examine some specimens from a case operated on by Dr. Alloway, in which there had been a double tubal hemorrhage, arousing the suspicion of a bilateral ectopic gestation. In one of the tubes I readily found villi, though in the other there was no evidence of any chorionic tissue. The case, however, is suggestive as possibly being one similar in nature to that described by Dr. Webster.

In one of the recent numbers of the *British Medical Journal* there is a synopsis of an article from Chrobak's clinic in Vienna, referring to a case of ovarian pregnancy, which, however clear, seems to be none other than an ampullar tubal pregnancy if one regards the original site of the placenta. The ovary, as in our own case, forms a portion of the sac wall, and the ligament of the ovary enters directly into the sac, but nevertheless the placenta itself is described as being fixed to the uterus.

*Pelvic Hæmatoma Complicating Malignant Disease.*—Mrs. J. McC., aged 39 years, entered the Royal Victoria Hospital in July, 1896, complaining of pain in the right inguinal region radiating towards the umbilicus. This pain began in January, 1896, was of a dull aching character and remained constant for seven days, during which time the bowels were rather constipated. For the first three days there was constant vomiting, and the abdomen was somewhat distended; after the pain disappeared there was tenderness in the right inguinal region for a week. Since January, 1896, she has had intermittent attacks of pain in the same region, but no vomiting until June, when she had an attack similar to that in January, accompanied by vomiting and chilliness with constipation. Since then she has had

constant pain in the right inguinal region radiating towards the umbilicus with a sensation of dragging downwards of the navel. The patient has had three children and one miscarriage, the last child three years ago; the miscarriage seven years ago. Menstruation regular, at intervals of three to four weeks, duration three days, quantity moderate, no clots. On examination the abdominal wall was lax, with a tolerably thick layer of subcutaneous fat. Striæ fairly well marked, moderate tenderness in the umbilical region. No descent of either kidney. In the hypogastrium immediately above the brim and rising quite to the level of the upper surface of the pubes is a firm, rounded, smooth and sensitive tumour. Per vaginam; the cervix is cleft bilaterally, granular and everted, the os is patulous and admits the tip of the finger. The cervix is directed to the left side of the pelvis. To the right of the cervix is a moderately firm mass partially movable and continuous with the mass felt in the hypogastrium. The sound enters three inches and is directed to the right side. There is scarcely any mobility of the uterus independent of the mass.

Operation, July 31st, 1896.—*Abdominal Section.*—The omentum was adherent to a pelvic mass and to the brim of the pelvis. Several coils of intestine were also very firmly adherent to the mass. These were separated by the scalpel leaving portions of the sac wall attached to the gut. The sac lay in the vesico-uterine pouch adherent, but not very intimately. It was enucleated and tied off with cat-gut; the pedicle being composed of the right ovary and tube. The left tube and ovary were also removed. During enucleation the sac was partially ruptured and black fluid blood and portions of partly decolorised clot escaped, the oozing from the vesico uterine pouch was controlled by pressure and the thermo-cautery. No drainage. Recovery speedy and uneventful. Discharged August 26th, 1896.

The specimen from this case was sent to the Laboratory on July 31st, 1896, and was found to consist of two distinct portions: (1) a large mass of tissue to which was attached the right ovary and tube, and (2) the left normal tube with a slightly cystic left ovary.

The large mass measured 14 cm. in greatest diameter, was moderately well encapsulated, and the tube which was of normal thickness could be seen stretched out upon the surface. On section the mass was seen to consist of shreddy friable material throughout, dark brown-red in colour, evidently containing much blood pigment. The whole friable mass appeared to be loosely held together by a moderate amount of fibrous framework. The central portions presented far greater disintegration than did the peripheral. The capsule itself varied in thickness, the average being 4-6 mm.

Microscopic sections were prepared from various portions of the mass. Those taken from the capsule and peripheral portions of the tumour, show a fairly dense fibrous tissue containing abundant blood pigment in crystals and amorphous granules, and a moderate degree of small round celled infiltration. The innermost portions showed a small number of epithelial cells arranged in an irregular manner amid the fibrous framework. Sections through the more friable portions of the growth revealed a tissue consisting almost entirely of epithelium and fibrous tissue. The epithelial cells were in parts arranged as glandular structures such as are seen in a multilocular ovarian cyst, but for the most part all trace of glandular arrangement was lost, and the irregular luxuriant growth of epithelial cells amid the stroma gave all the characteristic features of an adeno-carcinoma.

There was in addition abundant necrosis and a large amount of hæmatoidin. The tube was normal.

Pathological diagnosis. Adeno-carcinoma of the right ovary. Cystic left ovary.

*Pelvic Hæmatoma Associated with Tuberculosis of the Fallopian Tube.*—Mrs. L. J., age 34 years, came to the out-patient department of the Royal Victoria Hospital on August 14th, 1896, complaining of profuse discharges of blood per vaginam, pains in lower portion of abdomen and back, and tenderness in the hypogastric and right inguinal regions. Until the present illness patient has always enjoyed good health. The family history is phthisical. She has had eight children, but no miscarriage; labours all normal. Recoveries favourable. The last child April 11th, 1895. Menstruation was due on the 1st of July, but did not appear till the 4th, continuing till the 14th, when it ceased, and the patient began immediately to have hypogastric pain which continued till the next menstrual period. Since then she has had attacks of flooding with severe pain in the intervals. On July 30th she passed a large clot from the vagina.

*Examination.*—Abdominal wall tolerably fat, flabby and somewhat pendulous, striæ well marked, marked pigmentation from umbilicus to pubes. Tenderness in hypogastric, right inguinal and iliac regions. No descent of either kidney, no tumour or mass to be felt.

*Per Vaginam.*—Skene's glands inflamed, a purulent looking discharge can be squeezed from their orifices. Vaginal orifice torn and much relaxed, no evidence of disease of vulgo-vaginal glands. Descent of vaginal walls. Cervix bulky, thickened, firm and patulous, a bloody mucous discharge escaping. Uterus retroverted, its mobility diminished. To the right and behind the uterus an elastic, exceedingly

tender, pulsating mass. The patient was admitted to the gynæcological ward of the Royal Victoria Hospital.

OPERATION, August 19th, 1896.—*Dilatation and Curetting.*.—Result moderate in quantity, endometrium roughish to the curette. Gauze packing.

*Abdominal Section.*—Intestines adherent to a mass in the true pelvis. After separation of some adhesions a cavity containing eight to ten ounces of black blood clot was opened and evacuated. In the floor of the pelvis lay the right ovary as large as a medium sized orange, adherent and containing a straw-coloured transparent liquid. The corresponding tube was dilated and contained a blood clot partly decolorised. Chain ligature of cat-gut and removal. The left ovary was also expanded into a cyst at least two inches in diameter. It was removed. The left tube was not removed, it was adherent but not enlarged to any extent. No drainage. Recovery speedy and satisfactory. Discharged September 8th, 1896, apparently in perfect [illegible]th.

[illegible]is specimen which was sent by Prof. Wm. Gardner on August [illegible], 1896, consisted of a large hæmatoma—two ovaries and two tubes.

The one ovary (Rt.) was enlarged to more than twice its normal size, was mainly transformed into a bilocular cyst with generally thin walls and containing clear gelatinous fluid.

Attached to this ovary was an enormously distended and thickened tube evidently closed at both extremities. Its contents were hæmorrhagic in nature, its wall for the most part much thickened and distorted, the inner lining dotted over with fairly large tubercles and very few ragged portions of tissue. About midway, the wall was much thinned, shreddy, and showed a large irregular perforation evidently the original source of the hæmatoma of the broad ligament. The other ovary was enlarged to twice its normal size, firm, and with an apparently normal tube.

The existence of a hæmatoma associated with tuberculosis of the Fallopian tube seems to be an event of considerable infrequency inasmuch as the literature on the subject seems not to consider its occurrence at all, and yet in the very nature of tuberculous processes the occurrence of hemorrhage is to be looked for rather than otherwise. Just as the exudates of tuberculous peritonis and pleurisy are for the most part hæmorrhagic, so, too, one might expect a similar occurrence in the chronic diffuse miliary tuberculosis of the Fallopian tubes.