

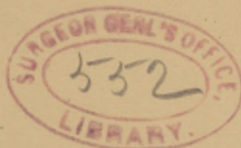
Smith (C. N.)

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REPRINTED FROM THE
AMERICAN GYNÆCOLOGICAL AND OBSTETRICAL JOURNAL
FOR MAY, 1896.





TUBAL ABORTION.*

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In the following case of ectopic pregnancy the diagnosis was not made until the abdomen was opened. The patient had lived apart from her husband for several months prior to her entrance into the hospital. As there were no reasons for suspecting the woman to be guilty of sexual irregularity, and as she avoided reference to this subject, ectopic pregnancy was not suspected. The history of the case, as here related, was obtained after operation, and only when the patient was confronted with the pathological proof of her condition.

CASE.—M. V., aged twenty, married at fifteen, never before pregnant. She menstruated first at thirteen, and, until her marriage, the flow was always regular and painless. Two weeks after marriage she contracted gonorrhœa from her husband, and was confined to bed for two weeks with pelvic inflammation. It was about three months after this attack before she was able to do housework. Since the attack of gonorrhœa the menses have been painful, scanty, and of but two days' duration. The patient has not lived with her husband since December, 1893, but now admits that she has been exposed to impregnation many times since that date.

Menstruation appeared, as was expected, on April 20, 1894, and was in every respect similar to her usual periods. On the night of

* Read by invitation before the Chicago Gynæcological Society, March 20, 1896.

route followed by the hæmorrhage and ovum is through the unclosed abdominal ostium of the tube and not through a rupture in its wall. The case here reported might readily have been mistaken for hæmatocele from reflux of menstrual blood had the abortion been complete and had it been followed by absorption or artificial evacuation of the fluid.

During the early weeks of gestation the attachment of the ovum to the tube through the villi of the chorion is slight, and renders the life of the ovum most precarious, especially if it be situated in or near the outer third of the tube. Slight contractions of the tube, or hæmorrhage into or about the foetal structures, may be sufficient to partially or completely dislodge the ovum, which may or may not be expelled into the peritoneal cavity.

When complete abortion occurs very early in gestation the hæmorrhage should cease, and should not recur, for, the tube being empty, there no longer remains an exciting cause of hæmorrhage. On the other hand, when the separation of the ovum has been but partially accomplished, hæmorrhage is prone to either continue or recur, as in incomplete uterine abortion, from further separation between the foetal and maternal structures. When the ovum is expelled from the tube and the hæmorrhage has not been extensive, absorption of both ovum and blood may follow. If the blood be evacuated by abdominal or vaginal section, the ovum may be so entangled in a blood clot, or may so closely resemble the latter, as to be entirely overlooked. In any of these events an incorrect diagnosis of hæmatocele from reflux of menstrual blood or from simple tubal hæmorrhage might readily be made.

Tubal abortion can only occur during the first eight weeks of gestation. Closure of the tube, which begins about the sixth week, is ordinarily complete by the eighth week, after which the ovum can escape only by rupture of the tube. The maternal blood-vessels steadily increase in size from the time of impregnation to that of abortion or rupture. The earlier the abortion takes place the less will be the amount of hæmorrhage, provided the abortion be complete. In early abortion, for the same reason, the hæmorrhage and consequent formation of the hæmatocele will be gradual. This gradual occurrence, coupled with the early arrest of hæmorrhage, gives opportunity for the formation of adhesions between the uterus, omentum, and intestines which circumscribe the escaped blood. In a very small proportion of early cases slight hæmorrhage may occur into the ovum, which renders it apoplectic, but may not cause its dis-

charge from the tube or produce a hæmatocele. An apoplectic ovum may undergo absorption without the production of further symptoms.

The question of operative interference in free or in recurring hæmorrhage from tubal abortion has been absolutely settled, but that of non-recurring, circumscribed hæmorrhage is still open. It can not be denied that in some cases absorption ultimately takes place and the patient regains her health. The period of convalescence is, however, frequently tedious, stormy, and dangerous. At best, a diseased tube and dense adhesions between the pelvic and abdominal organs remain to menace the woman the remainder of her life. If the blood be not absorbed, suppuration may occur, and this complication, although comparatively infrequent, must be looked upon as one which threatens every intraperitoneal hæmatocele. When suppuration takes place operation is inevitable, and must be done under comparatively unfavorable circumstances.

I can not but feel, even in the face of able and strong opposition, that for the immediate, as well as for the ultimate, safety and comfort of the patient, operation should be instituted in every case of intraperitoneal hæmorrhage, be it circumscribed or free, recurrent or non-recurrent.

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