

✓ Baldy. (J. M.)

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Pyosalpinx

Baldy

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THE RELATION
OF
PYOSALPINX TO PUERPERAL FEVER.

BY
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THE RELATION OF PYOSALPINX TO PUERPERAL FEVER.

BY J. M. BALDY, M.D.

[Read June 22, 1887.]

UNTIL within a few years the term "Puerperal Fever" has been applied to certain conditions of the parturient woman without conveying any very definite idea as to the exact pathological lesion involved. As in microscopy we designate everything that we are unable to recognize by the general term "molecular débris," so in the parturient woman we have been in the habit of applying the meaningless term "Puerperal Fever" to a set of symptoms, the origin and source of which we knew not. As usual in such a condition of ignorance, an innumerable number of theories sprang up on the subject—the most widely accepted of which was probably that advocated by Fordyce Barker, viz., that it is a specific febrile disease.

Thanks to the zeal of bacteriologists, we have now conquered our ignorance and can state without hesitation or fear of successful contradiction that the disease under discussion is of undoubted septic origin. We are therefore justified in dropping the ambiguous term of the darker ages and applying terms more in accordance with our advanced knowledge of the pathological lesion. I have no intention of entering into an exhaustive discussion of all the phases of puerperal septicaemia, but shall briefly try to add something to our knowledge of the particular subdivision which, for want of a better name, I shall call puerperal pyosalpinx.

The belief that a certain proportion of our so-called puerperal fever cases are simply cases of salpingitis septica is by no means a new one, nor is it original with myself. Martin, in a recent investigation, has found the microorganisms of puerperal septicaemia in as many as seventy out of a series of two hundred and eighty-seven cases of inflammatory tubal trouble.

Schröder held that septic endometritis of the uterus did not ex-

tend to the tubes, *as a rule*; but he qualified this opinion by following it up closely with the remark that *occasionally* the endometritis did go on to a purulent salpingitis. Nor is Sanger silent on this subject, for he has only recently stated in a letter read before the Chicago Gynecological Society, in answer to one from Mr. Tait, "that salpingitis septica, coexisting with severe puerperal septicaemia has never as yet given the surgeon an opportunity to remove the principal focus of disease by extirpation of the tubes. It is possible, however, that under certain circumstances such a procedure might be indicated." Even before these words of Sanger's were in print the opportunity to remove the principal focus, and, I may say, in this case the only focus, of disease, *had* occurred and been taken advantage of by the surgeon, as witness the following case:

Mamie P., twenty-three years of age, was delivered of a male child after a tedious but normal labor, some four years ago. She was at that time confined to her bed for eight weeks with "an inflammation in the stomach." She, however, made a good recovery, and has never suffered from a pain or ache in her abdomen since—she has, in fact, considered herself a typically healthy woman. On February 3d, last, I was called to attend her in her second labor. Although going with the messenger I found the labor over—a dead child together with the placenta, with all its membranes intact, lying between her thighs. Her bare arms, chest, and legs were exposed in a room without a fire. No examination was made, but she was put between warm, dry bed-clothes as quickly as possible. On the second or third day she had a chill, with a quick rise of pulse and temperature, a tympanitic and tender abdomen. These symptoms abated somewhat, and I lost sight of her for several weeks. On the third of March, just one month from the date of her confinement, I was again summoned to her and found that she had been suffering ever since I had last seen her; she was at this time so emaciated that I hardly recognized her as my former patient. Her temperature was over 102°, her pulse over 130; she was having continued chills and creeps, hectic, night sweats, and sleepless nights; her abdomen was swollen and tympanitic, and intensely painful; her bowels were loose and fetid; micturition and defecation were both painful—she was evidently fast approaching death. An examination of the soft parts showed no signs of a recent tear; the uterus was subinvolved, and on the left side there was a large boggy mass, firmly adherent, tortuous, and extremely tender. The right side was tender, but no mass could be detected. Abdominal section was advised as the only remaining hope of saving life, and the proposition was eagerly accepted by both herself and friends.

Dr. Joseph Price saw the case with me and confirmed my opinion of immediate operation. I operated on the fifth of March (the delay being necessary in order to have her surroundings cleansed); Dr. Price, of Philadelphia, Dr. McMurtrie, of Danville, Ky., and Mr. Eckman, of Scranton, Pa., being present and assisting. The right tube and ovary were found healthy and were not removed. The left tube was found almost as large as the uterus

and firmly adherent in all directions, especially to the bowel, from which it was separated with the utmost difficulty. An abscess of the cellular tissue was ruptured while breaking up the adhesions, and pus welled up through the abdominal incision. Both tube and ovary were removed. A large cheesy mass on the bowel at the point of adhesion was trimmed down with scissors and an application of Monsel's solution made to the bleeding points. After a free irrigation a drainage tube was put in and the incision, which was only one and a half inches in length, was closed with three deep silk sutures.

On examination the tube was found to be distended with pus; the ovary was broken down and contained pus. The patient rallied quickly from the ether and had no shock. Her pulse fell to 80 and her temperature to almost normal within twelve hours, and remained so until about the seventh day, when the drainage tube was removed. Up to this time she had done as well as possible under the circumstances. There had been little or no pain, no catheter, bowels opened naturally; no drugs of any kind had been administered. The day after removal of the tube her pulse began to rise, as also did her temperature; pain developed in her left ovarian region, and she began to have hectic and cold creeps. About the eleventh day there was a free gush of pus from the tube tract and she began to improve again from that moment. A rubber tube was inserted and passed deep into the pelvis and the abscess was washed out twice daily. The discharge gradually diminished and the tube was again removed. The wound is now completely healed and the patient is a well woman.

That these cases exist much more frequently than we have any idea is certain, and that oftentimes a life, otherwise doomed, can be saved by operative interference is but a natural conclusion. Mr. Tait mentions four deaths from this cause in Queen Charlotte's Hospital, as verified by post-mortem examinations, and says that "these cases during life were all regarded as puerperal fever." Sanger comes forward with two cases which have come to his knowledge in which the overdistended tubes burst and discharged pus into the abdominal cavity, with death on the fourth day after confinement in one case, and on the twenty-first day in the second case. Who can doubt that, in the light of our present surgical knowledge, if these cases had been recognized and operated on, the women would have all survived? The day has passed, I hope, in which we will allow a woman to die of pus in her abdomen without at least proposing an abdominal section, not merely as a last resort, but as an early means of relief and safety. It is by no means to be held that because a parturient woman has an inflammation of her tubes, she is to be rashly submitted to the knife of the surgeon. I have, within the past few months, seen a woman who presented an elevated temperature, with anorexia, restless nights, and other general symptoms, and whose tubes, on examination, I found enlarged and painful. Under careful treatment this local trouble all

subsided, and with it the general symptoms disappeared and the patient made a satisfactory recovery. These mild cases, however, often go on to a chronic condition, when unrecognized and neglected, and the woman eventually falls into the surgeon's hands to be relieved of a pus-tube, and then generally gets the credit of having had a gonorrhœa at some period of her life, or else drags out a miserable existence until she dies of her trouble, or some other disease puts an end to her suffering. The following case fairly illustrates this :

Maggie F., thirty-one years old, married thirteen years, has had one miscarriage and five children. Had always had good health until her last confinement, six or seven years ago. At this time she had a slow and tedious "get up." Her physician told her that she had "an inflammation in her stomach." She was confined to bed for several months. She has never been well since that time; has been constantly losing flesh, suffered from pain, and has generally felt wretched, not able to work half the time. I was called to attend her on the 31st of March, last, and found her suffering with peritonitis, of which she had been getting gradually worse for the past three or four weeks. An examination disclosed a pyosalpinx firmly bound down and extremely tender. I made an abdominal incision and removed a large and densely adherent tube and ovary, both filled with pus, from the right side. Recovery was uninterrupted, and she has been relieved not only from her peritonitis but from all her old sufferings. The last time I saw her she told me she was feeling more and more like herself, and was fast regaining her former weight.

The only regret I have in either of these cases is that I did not remove both appendages. The case Mamie P., has recently had an inflammatory attack in the remaining tube, from which she has recovered, but I am afraid the time will come when another operation will be required. I think where pus is found that both sides should be removed always, whether one side is apparently healthy or not, the patient being willing, of course.

Whether or not this disease arises *de novo*, or, having already existed from other causes, has simply a new inflammation added by the puerperal condition, must be determined by careful investigation in each case. Hecker, as early as 1878, mentions two cases in which an old pyosalpinx was lit up by the puerperal state, and Sanger adds another from his own practice in which the salpingitis had a prior existence. In the case of Mamie P., the patient was apparently perfectly well up to the time of her last confinement, but the adhesions were of such a firm character that it is safe to presume that there was an old inflammatory trouble prior to this time. It is impossible to imagine the formation of such organized bands in so short a space of time. At her first confinement she had "an inflammation in her stomach" and that was the probable beginning of her trouble. She undoubtedly has had tubal disease ever since (probably

pyosalpinx) and has not suffered enough inconvenience from it to seek advice. This is often the history of these women; they complain of pain and general ill-health, loss of flesh, anorexia, and sleepless nights, etc., but oftentimes they do not even suspect the real origin of all their trouble. The result in the case of this particular patient is a valuable lesson of the dangers of such a neglect, and is an additional reason why the disease should always be removed when recognized.

Of course, the possible contagion of gonorrhœa can never be eliminated excepting by a microscopical examination. In both my cases, although the trouble seemed very clearly to have arisen at the time of confinement, yet the chances of gonorrhœal infection both before and after pregnancy are not to be denied; however, in lieu of a microscopical examination, the chances are all in favor of a purely puerperal origin. But whatever the source, the results are the same, and it is only by prompt measures we may hope to save some of these cases. It is no longer surprising that even under the most careful antiseptic treatment of the uterus, vagina, and person of the patient as well as the person of the attendants that still patients are lost from septic poison. This disease has been recognized and operated on at least four times in Philadelphia; one case was operated on just two weeks previous to mine, by Dr. Longaker, in which a pyosalpinx was removed, the patient dying on the second day. I may state here that this operation was delayed three or four days after an abdominal section had been urged. Dr. Joseph Price has since operated twice, and in one case found more than a quart of pus in the abdominal cavity; the case, unfortunately, came into his hands too late and the patient survived only two days.

These cases, though few in number, certainly teach us that the work done in this direction is encouraging, and although a large percentage of the patients have died, it only warns us of the extreme importance of an early diagnosis and prompt surgical interference. It becomes our imperative duty in every case of post-puerperal trouble to make a thorough investigation on the appearance of the first symptoms, and should a fulness be found on either or both sides of the uterus, accompanied with pain on touch and with constitutional symptoms of gravity, there should be no hesitation as to the course to pursue. This being secured, our present high mortality of one woman out of every hundred delivered in large cities, as recently stated in a statistical paper on lying-in charities in the United States, must be very largely diminished and the fatal results now surrounding our parturient women must become infinitely less.



