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# The Medical Fortnightly

BY BRANSFORD LEWIS, M. D.

Lecturer on Genito-Urinary Surgery and Venereal Diseases, Missouri Medical College; Consultant Genito-Urinary Surgery to the Missouri Pacific Hospital, the City Hospital, the Female Hospital, and to St. Mary's Infirmary, Saint Louis; member of the American Medical Association, the National Association of Railway Surgeons, and the American Association of Genito-Urinary Surgeons.

COLLABORATORS:

DR. NICHOLAS SENN, Prof. of Surgery, Rush Medical College, Chicago.
DR. JOSEPH PRICE, Philadelphia.
DR. LANDON CARTER GRAY, New York.
DR. J. C. MULHALL, Prof. Diseases of Throat and Chest, Beaumont Hospital Medical College, St. Louis.
DR. J. K. BAUDUY, Prof. Psychological Medicine and Diseases of the Nervous System, Mo. Medical College, St. Louis.
DR. HENRY SCHWARZ, Prof. Gynecology, St. Louis Medical College.
DR. H. N. SPENCER, Prof. Otology, Mo. Medical College, St. Louis.
DR. SALOMON EHRMANN, Privat-Docent for Syphilis and Dermatology, University of Vienna, Austria.
DR. H. C. DALTON, Prof. of Abdominal and Clinical Surgery, Marion-Sims College of Medicine, St. Louis.
DR. GEO. HOMAN, Prof. of Hygiene and Forensic Medicine, St. Louis Medical College.
DR. H. M. WHELPLEY, Prof. Physiology and Histology, Director of Histological Laboratory, Mo. Medical College, St. Louis.
DR. FERDINAND KING, New York City.
DR. N. B. CARSON, St. Louis.
DR. ERNEST FINGER, Privat-Docent for Syphilis and Dermatology, University of Vienna, Austria.
MR. E. HURRY FENWICK, Surgeon to London Hospital St. Peter's Hospital, London, Eng.
DR H. TUHOLSKE, Prof. Clinical Surgery and Surgical Pathology, Mo. Med. College, St. Louis.
DR. W. B. OUTTEN, Dean, and Prof. of Surgery, Beaumont Hospital Med. College, St. Louis; Chief Surgeon Mo. Pac. Ry. System.
DR. GEO. H. ROHE, Supt. Maryland Hospital for the Insane, Catonsville, Md.; Prof. Obstetrics and Hygiene, Coll. of Physicians and Surgeons, Baltimore
DR. W. E. B. DAVIS, Sec. Southern Surgical and Gynecological Association, Birmingham, Ala.
DR. F. R. FRY, Prof. Neurology, St. Louis Med. College
DR. W. A. HARDAWAY, Prof. Dermatology, Mo. Medical College, St. Louis.
DR. PAUL PAQUIN, Superintendent "The Gasconade," Lebanon, Mo.
DR. H. N. MOYER, Adjunct Prof. Practice of Medicine, Rush Medical College, Chicago.
DR. GEO. J. ENGELMANN, Prof. of Diseases of Women and Operative Midwifery, Mo. Med. College.
DR. J. P. BRYSON, Prof. of Genito-Urinary Surgery, St. Louis Medical College.

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## Some Further Experience in the Dilatation of the Fallopian Tube.


BY WALTER B. DORSETT, M. D.,

ST. LOUIS.

Professor of Diseases of Women and Clinical Gynecology, St. Louis College of Physicians and Surgeons; Gynecologist to St. Louis Deaconesshaus; Consulting Gynecologist to City and Female Hospitals; Ex-President St. Louis Medical Society; Secretary of St. Louis Obstetrical and Gynecological Society; Member American Association of Obstetricians and Gynecologists; Member of St. Louis Surgical Society.


**Abstracted from a Paper Read before the Missouri State Medical Society, May, 1893.**

UNDER the title of "The Location of Tubal Abscess as an Indication for its Treatment," I read a paper before the St. Louis Surgical Society on June 15th, 1892, in which I deprecated the tendency on the part of some members of the profession to laparotomize every case of pyosalpinx, and made a plea for a more conservative method of treating cases of abscess of the tube when located in proximity to the uterine horn.

In presenting this paper I wish to be stringent upon my professional brethren who do much abdominal surgery upon the female. I claim that in certain inflammatory troubles of the tubes it is not necessary to open the belly and take out the tubes and ovaries. There are, as we all must admit, cases of abscess located near the uterine end of the tube in which the contents have not leaked into the general peritoneal cavity, so also there are cases of hydro- and hematosalpinx in which the dilatation of the tube by its contents has not reached the fimbriated extremity. *These* are the cases to which I wish to draw attention and submit a treatment based upon anatomical grounds, upon the observation of many cases, fortified by a number of cures, the histories of which I will detail in this paper.

I have opened the abdomen and extirpated the tubes and ovaries a number of times, but as my experience has advanced, so have my doubts increased as to whether my practice was, in every case, justifiable; and while I have every reason to believe that the results of my laparotomies compare favorably with other gynecologists, I am not prepared to give you as large a percentage of cures as I would like. And while the utmost precautions may be practiced in the way of antiseptics, we all have to admit that we now and then lose patients who ought not to have died. Who can say that this or that case, although seemingly a favorable one, will not die from shock, from persistent vomiting, from peritonitis, or that this or that case will not have a fecal fistula, or a ventral hernia, or that a ligature here or there may not slip and the patient bleed to death?

Then again, when once the abdomen is opened, what a tendency there is to take out both ovaries, when perhaps only one tube or, perchance, one ovary is the site of the trouble. The laparotomist will possibly give as his excuse for taking out both ovaries, that Dr. P. or Dr. G. always advises the extirpation of both ovaries when only one is involved in a gonorrheal or puerperal inflammation. In the justification of such teaching it may be said that the non-extirpation of a gonorrheal tube maintains a constant source of danger, and that such cases never recover. I must say I cannot, in the light of personal experience, subscribe to such a declaration. It does not stand to reason that the tube should be extirpated because it once contained pus, any more than that any portion of the genital tract in the male should be extirpated because it once was the site of a previous specific catarrh.

I do not wish to be understood as being opposed to the extirpation of pus-tubes and ovaries affected with suppurative troubles, when such a course is the only one left open to follow, but I do think that many tubes and ovaries can be treated in a different way.

The conclusions I have arrived at are based upon observation of cases under my care while occupying the position of Superintendent of the St. Louis Female Hospital, and extended over a period of nearly five years. These observations are as follows:

1st. I have noticed that in tying off diseased tubes in cases of tubal abscess that was located near the uterine horn, that the ligature would frequently cut through the tube, and that occasionally several attempts

would have to be made before the ligation could be done, and then it was not done satisfactorily.

2d. That tubal abscesses, whether they were located near the uterine end or not, were primarily near the uterus.

3rd. That gonorrheal tubal troubles were more frequent in cases that had shown no symptoms of a previous chronic endometritis.

4th. That gonorrheal salpingitis frequently existed without a corporeal inflammation of the uterus, and consequently, we do not find, in these cases, a patulous os, but, on the contrary, the cervix is firm and the cervical canal is not easily dilated; therefore, there is no provision furnished by nature to drain the septic cavity, and as a natural order of things, the virus, in its proliferation, travels upward and into the tube, instead of downward, as would be the case if the os were patulous.

5th. In my daily bi-manual examinations of pelvic cases, I have frequently felt inflammatory swellings located near the uterine horn, and on several occasions I have been enabled to knead pus into the uterus with my index finger in such quantities that it would flow out of the cervix uteri into the vagina, demonstrating the fact that tubal abscesses do sometimes voluntarily open into the uterus.

To aid and assist Nature in all things pertaining to the cure of diseases, is not only the duty of the physician, but in the practice of medicine and surgery, it is the only rational thing to do; and when she points out the way, and we fail to follow, we are sure to go wrong.

For the purpose of better understanding the rationale of the treatment pursued in these cases, let us for a moment consider the anatomy of the tube.

It has three coats—an external, serous; middle, muscular; and internal, mucous. For our purpose, the muscular and serous, only, need be considered. The diameter of the tube, we know, is not uniform throughout the entire length. At the uterine end the diameter is 0.13 inch; in the middle, 0.23 inch; while at the abdominal extremity it is 0.31 inch. Fallopius has properly compared it to a trumpet in shape and general contour, the uterine end representing the mouthpiece, the intermediate portion between this and the pavilion representing the body of the instrument, and the pavilion the expanded portion, or flange.

The muscular coat, we are told, consists of two layers—an external, composed of longitudinal fibres which are formed from the prolongation of the fibres of the uterus; and an internal layer of circular fibres beginning at the uterus, where it forms a sphincter and is continued outward toward the abdominal end.

The muscular fibres of the uterus which here concern us, are the following: 1. The external layer of the fundus, arranged transversely as a plane on the anterior, superior and posterior surfaces of the upper uterine segment, and converging at the origin of the tubes. The middle layer, arranged in an irregular manner, does not materially affect the consideration of the subject. 2. The internal or deep coat, consisting of circular fibres arranged in the form of two hollow cones, the apices of which surround the orifices of the tube, so we may consider that we have here two cones, the

apices of which are in apposition, the one being the fallopian tube and the other the one-half of the uterus.

Now suppose we should take a hollow cone, constructed, for example, of paper or pasteboard, and should systematically pack in to the apex of this cone any soft material until the packing is firm, would it not have a tendency to dilate the apex? Now, in these cases we do exactly the same thing, and by allowing this packing to remain in for from twenty-four to forty-eight hours, there is produced a muscle-tire of exhaustion, and relaxation necessarily takes place, and a communication between the abscess cavity and the cavity of the uterus is established, followed immediately by a profuse flow of pus. In following this procedure, I have noticed that in several cases I have found, on exposing the cervix, that the os was small and tight and that it was only with some difficulty that I could get any considerable amount of gauze past the internal os, but on the second day the uterus presented an entirely different aspect; it was always soft and easily dilated, so that the uterus could be easily packed to the fundus and into the horn, and on the third day, when the gauze was withdrawn, it was followed by a flow of pus.

Now as to the technique of the operation: When once the diagnosis is established that we have to deal with an abscess of the tube, located near either horn of the uterus, or that we have a collection of aqueous material or blood filling the tube, and that only the sphincter of the tube prevents its discharge into the uterus, the patient is prepared in the same manner and with as great care as she would be should we intend to make a laparotomy.

The evening before the operation the bowels are evacuated and a hot, bichloride vaginal douche is given, 1-4000. The day and hour decided upon, the patient is placed upon the table in a Sim's position, the perineum is retracted with the short blade of a Sim's speculum and the uterus drawn down with a vulcellum forceps. The uterine dilator of Peasely is introduced and the neck slowly dilated to the extent of one inch, if possible; a small sharp curette is then introduced and the cavity thoroughly scraped out. A uterine irrigator is then introduced and the cavity is washed out with a solution of bichloride of mercury of the strength of 1-4000. Narrow strips of 10 per cent iodoform gauze are then systematically packed into the uterine cavity, a constant effort being made to pack the side next to the inflammatory swelling tighter than elsewhere, or, in other words, the apex of the uterine cone is packed as tight as possible without using too much force, for should the applicator slip off the gauze, the uterine wall might be punctured.

Enough gauze is used to fill the uterus and about one inch of the end of these strips is left hanging out of the cervix. The vagina is then packed moderately tight with bichloride or iodoform gauze and the patient put to bed and, if necessary, given a hypodermic injection of morphine; this, however, in the majority of cases has not been necessary, as very little pain follows the treatment.

The instruments used are a Sim's speculum, a uterine irrigator and a small whale-bone applicator with which the packing is done. There has

been devised a uterine-speculum as well as a uterine dressing-forceps for packing the uterus, but these instruments are unnecessary and useless.

The end of the narrow strip of gauze is laid over the os and the point of the whale-bone applicator pushes the gauze into the uterine cavity as far toward the uterine horn as possible at one effort. Being smoothly polished it is easily withdrawn and does not drag back the gauze, as does the uterine dressing-forceps of Polk. Within twenty-four to forty-eight hours the gauze is removed from the vagina and uterus, and the uterus is washed out and repacked as before. It is seldom necessary to repeat this operation more than twice to effect a thorough evacuation of the abscess. The patient is kept in bed from eight to ten days and then allowed to go about her usual duties. I have, up to the present time, treated in this manner twelve cases of tubal abscess and one of hematosalpinx. Of the twelve abscess cases, three were bilateral and nine were unilateral. Five were of gonorrheal origin. Four were puerperal and one was, in all probability, caused by unclean instruments in the hands of a physician who was treating the patient for a supposed case of endometritis. In two the origin of the trouble could not be fully determined.

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In the discussion of this subject students of pathology may say that inasmuch as gonorrhea is a disease of the sub-mucosa as well as the superficial mucous membrane, when a narrow canal like the Fallopian tube is once the seat of an inflammation, such as would be produced by gonorrhea or infectious material from a necrotic placenta, irreparable damage has been done, and that an extirpation of the tubes alone will suffice to effect a cure. Again, it may be said that, remotely, menstruation will be interfered with after the changes incident to a high degree of inflammation has subsided, that strictures of the tubes will follow. In answer to this I will say that such troubles have not followed the cases delineated in this paper.

Of course the operation is limited in its sphere to only cases in which the inflammatory swelling is located near the uterine horn, and in which the tumor is found on bi-manual palpation to be continuous with the uterine body. Should a sulcus intervene between the tumor and the uterine body, it is then clearly a case for abdominal section. And should the inflammatory, and possibly fluctuating, tumor be in the cul de sac of Douglass, the very location of the tumor demonstrates the fact that either leakage has taken place and that in all probability the ovary is prolapsed and diseased as well, and that the case is one for vaginal retro-uterine puncture or abdominal section.

If the collateral symptoms and history should point towards a tubal abscess in a fleshy patient, where it would be impossible to clearly define the anatomical relations of the tumor by bi-manual palpation, I would first try dilatation before subjecting my patient to a laparotomy, everything else being equal. Of course there are cases in which urgent symptoms may arise and demand laparotomy at once. In such cases the patient should be accorded the benefit of the radical operation.

The *time* for dilatation is when we are thoroughly certain that we have a pus-sac to deal with, and during the early inflammatory stages. Delays are dangerous, for by proliferation the pus may soon find its way into the abdominal cavity through a ruptured abscess wall or through the pavilion.

Every case is a law unto itself and should be treated accordingly, bearing in mind the fact that laparotomy is not demanded in every case.

Allen B. Dorsett

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**Consultants to the City Institutions.**—The following resolutions were passed at the last meeting of the St. Louis Board of Health:

WHEREAS, In view of the indefiniteness and insufficiency of official information as to who has been appointed consultants to the different hospitals under city control and are now holding such positions, the terms of such appointments and the duties and obligations toward the city of those holding them, it is desirable that a clearer understanding in this regard be had, and some definite rule be followed in future; therefore be it

*Resolved*, That the Board of Health hereby reconsiders its action in this respect, and vacates and annuls all existing appointments of this kind. And be it further

*Resolved*, That the proper committee be instructed to prepare and submit to the Board a rule or plan to govern all such appointments in future.

The foregoing preamble and resolutions were adopted by the Board of Health on July 20 last, the object being to formulate a systematic plan by which appointments to the various institutions may be made in future.

DR. OTTO E. FORSTER.

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## NECROLOGIC.

Dr. P. Ten Eyck of Albany, New York, at the age of 91.

Dr. Samuel E. Munford, of Princeton, Indiana, of tuberculosis.

Dr. Henry Fisher, dentist, of 321 Forth Grand Avenue, died suddenly, August 1st.

Dr. James O'Rorke, one of the Board of the St. Vincent's Hospital, New York, July 30th.

Dr. Charles P. Strong, one of Boston's most esteemed surgeons. He was infected during an operation on a septic subject.

Dr. Israel, for many years assistant to Professor Virchow, of Berlin, and Extraordinary Professor in the Berlin University.