DISEASES OF THE FALLOPIAN TUBES AND HISTORIES OF FOURTEEN CASES OPERATED UPON AND REPORTS ON SPECIMENS

Published @ 2017 Trieste Publishing Pty Ltd

ISBN 9780649297832

Diseases of the fallopian tubes and histories of fourteen cases operated upon and reports on specimens by W. Gill Wylie

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Edited by Trieste Publishing Pty Ltd.
Cover @ 2017

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Reprinted from THE MEDICAL RECORD, *January 24 and February 7*, 1885

NEW YORK
TROW'S PRINTING AND BOOKBINDING COMPANY
201-213 EAST TWELFTH STREET
1885

W21
W98
1885

DISEASES OF THE FALLOPIAN TUBES.[1]

In looking up the literature of salpingitis, minute descriptions of the pathological anatomy will be found in the writings of Kiwisch, Förster, Rokitansky, and later Martin Klob, Schroder, Henning, and other German writers; but little advance was made in the treatment until a few years ago, when Mr. Lawson Tait made known his wonderful success in removing diseased tubes. The writings of Battey and Hegar on removal of ovaries also had an influence in developing the proper plan of treating diseases of the uterine appendages.[2]

Dr. J. Marion Sims, for several years before his death, was much interested in the subject, and, as his assistant, I helped him in a number of cases. But it was not until I was appointed one of the gynecologists to Bellevue Hospital and began my clinics at the New York Polyclinic, in 1882, that I had an opportunity to study clinically a large number of cases. Since then I have made a careful study of the subject, and since May, 1883, when I did my first operation for removal of diseased tubes, I have operated upon fourteen cases for diseased uterine appendages, not including operations for ovarian or uterine tumors. Each of the fourteen cases were under my observation and treatment several weeks before the operation, and many had been kept in my ward at Bellevue three, six, and one

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[1] Read before the New York Academy of Medicine, January 15, 1885.

[2] The author does not desire to discuss the claims of Tait, Battey, and Hegar, but there can be little question that, among the English speaking profession, Battey first made plain that we should operate upon certain forms of ovarian trouble besides ovarian tumors, and Lawson Tait first taught us that we should and could remove diseased Fallopian tubes in many cases. Hegar may have done the same thing in Germany.

or two even nine months beforehand. By a careful study of each case and by the use of preparatory treatment to soften and relax the adhesions, I was able, in almost every case, to make a more or less exact diagnosis before operating. Of these, nine were operated upon in either the Sturges or the Marquand pavilion at Bellevue Hospital, the remaining five were in private practice. Twelve recovered and two died of septicaemia on the fifth day; the latter were hospital cases. Eight were cases of pyo-salpinx; two hydro-salpinx, and four catarrhal tubes with peritoneal adhesions. With one or two exceptions, there were extensive adhesions from local peritonitis and the ovaries were either diseased or more or less covered with adhesions, and, in three instances, abscesses were found involving the extremities of the tubes and the ovaries. Short histories of each case were read, and twelve of the fourteen specimens, with a report on the specimens by Dr. H. C. Coe, Pathologist ogist to the Woman's Hospital of the State of New York, were shown last night at the New York Pathological Society. Many other cases were kept under observation and clearly diagnosed, but either because the patients objected to the operation, or the subjective symptoms did not justify it, they were not operated upon.

I am satisfied that a careful study of the diseases of the Fallopian tubes will not only clear up most of those numerous and once incurable cases of local peritonitis (in this country commonly called cellulitis), but also most of the cases of retroversion, retroflexion, and lateral flexions with adhesions, and that their proper treatment will make plain the uselessness and danger of using pessaries in such cases. I do not mean to say that every case of local peritonitis will be found due to salpingitis, but that, in the large majority of cases, salpingitis precedes the local peritonitis, and that repeated attacks of local peritonitis are, as a rule, caused by salpingitis.

In my opinion when the frequency and the great importance of diseases of the Fallopian tubes is generally

understood, the fascinating teaching of the mechanical pathologist, namely, that most of the ills of women are due to uterine displacements, that the real disease is the version or flexion, and when this is corrected and the uterus is held by a pessary in an ideal normal position that all will be well, will fade to small proportions and the relatively few lines now to be found in our text-books on salpingitis will increase rapidly, and there will not be so many hundred pages on cellulitis, displacements, and pessaries.

Etiology.—Anything which causes endometritis may induce disease of the Fallopian tubes, and it is probable that in most cases salpingitis is due to an extension of disease from the lining membrane of the uterus directly to that of the tubes. In virgins it is comparatively rare, except from catarrhal disease. In imperfectly developed and delicate girls and women, the degenerate state of the mucous lining makes it an easy prey to catarrhal disease, and an endometritis may be extended to the tubes. Tubercular disease may also attack the Fallopian tubes.

Many of the profession, especially those who treat genito-urinary disease in the male, look upon gonorrhœa in women as a very trivial disease, probably because it does not produce urethral strictures. When Dr. Noeggerath read a paper on this subject before the American Gynecological Society, in 1876, his views on gonorrhœa may have been extreme, but on salpingitis they were well in advance of the general knowledge on this subject at that time, and now, if the gonococci causes the disease and he can find the gonococci in all, or in most of his cases of latent gonorrhœa, his theory will be proven to be true. There is no doubt but that gonorrhœa is a very frequent and in many instances an unsuspected cause of salpingitis. Among prostitutes this disease and septic endometritis following abortions, by causing salpingitis, accounts for the incurable sterility so universal among this class, even though they return to the paths of virtue. Early in its course, before the poison has reached the deep-seated

glands of the vagina, or the lining membrane of the uterus, it may be checked in its course by repeated applications of a solution of a mercuric bichloride or some other antiseptic, but when once it enters the uterus it cannot safely be treated locally until it has become subacute, for any attempt to introduce even a small probe may cause uterine contractions and pains which are pretty certain to be followed by local peritonitis within the next twenty-four hours, and the probability is, that this is caused by the tube becoming infected by the contractions forcing the poison in from the uterus. Even when treated with the greatest care, specific endometritis will in many instances cause salpingitis and local peritonitis. I have selected several well-marked cases and put them to bed, and watched the course of the disease from the vagina to the uterus, from the uterus to the tube and peritoneum. Salpingitis from gonorrhœa may result in active pyo-salpinx with a thick yellowish or greenish pus, or it may become chronic and the discharge gleety and thin in character. The tubes may close at the fimbriated extremity, and after the first attack of local peritonitis drain into the uterus, but frequently after a time the tube becomes distended on account of a stricture of the proximal end, and the patient may have repeated attacks of local peritonitis, indicating that the adhesions which nearly always seal up the fimbriated extremity have yielded or the poison in some way has reached the surrounding tissues.

Syphilis may cause salpingitis, just as it does otitis or ozæna. Some of the most obstinate cases of endometritis that I have ever seen have been in syphilitic subjects.

Septic poisonings after labor and abortions, especially after the latter, is a frequent cause of salpingitis. After abortions the cervix uteri is not so patulous as after full term labor, the cervix being more irritable and likely to contract and obstruct drainage, and any effete matter may be not only retained in the cavity of the uterus, but when the uterus contracts it may be forced into the Fallopian tubes.

It may be a disease that induces the abortion, and this extends to the tubes. Besides, after an abortion, neither the patient nor the doctor are as likely to keep up the usual precautions and give time for involution to take place. Sub-involution and endometritis are much more common after abortions than after normal labor. It is my opinion that in most instances it is through the tubes that septic poison causes local peritonitis. Septic material is, of course, often absorbed directly from the uterine tissues by the blood-vessels and lymphatics, but the poison is carried into the circulation, and does not directly enter the peritoneal cavity. Local peritonitis is much more common on the posterior surface of the broad ligament than on the anterior surface, for the tube opens on the posterior surface of the broad ligament. My experience leads me to attach much more importance to local peritonitis than local cellulitis, for, except after septicæmia, where the poison has become localized in the cellular tissue, producing a phlegmon, the cellular tissue is, as a rule, merely affected by contiguity with the inflamed peritoneal tissue, and I do not believe in so-called "chronic cellulitis." Hydro-salpinx may be due to other causes than venereal or catarrhal disease, but in what way it has not been made clear to me, although I must admit that I have seen some cases not satisfactorily explained by saying that it is the sequel of catarrhal disease or subacute inflammation. Small thin cysts may be found on the outside of the tube, but these more properly belong to the broad ligament. Diseased tubes are very commonly associated with diseased ovaries, and I think in most instances the disease of the tubes precedes that of the ovaries, and the diseased ovaries are but the result of an extension of the disease from the tubes to the ovaries and peritoneum. But certain diseases of the ovaries may cause disease of the tubes, such as cancer.

In several cases I have found cystic disease of the ovaries associated with catarrhal disease of the tubes, and it is this combination which I have noticed in the

worst cases of hystero-epilepsy. In fact, if I have a well marked case of hystero-epilepsy or hysterical patient to operate upon, I expect to find cystic or atrophied ovaries with catarrhal disease of the tubes.

Hemorrhages into the tube may result in more or less permanent distention, and anything which stops up or diminishes the size of the lumen of the tube may obstruct drainage and result in disease and distention.

Symptoms and diagnosis.—The subjective symptoms are very variable. A peculiar burning pain over the seat of the tube affected is, perhaps, more characteristic than any other symptom, but many patients have no such pain, and local sensitiveness and a dull pain over the tubes and ovaries is about the only constant symptom; sometimes a dragging pain or sensation will be present when the patient stands, or there will be backache and headache, such as is supposed to be due to displacement, which are so commonly associated with, and are often due to the diseased tubes.

Dysmenorrhœa is a common symptom in these cases, but in some the flow gives relief by lessening the congestion, and I am inclined to believe that the pain is often caused by the endometritis, or the result of the endometritis in producing contraction and hyperæsthesia of the mucous membrane, for in those cases where all stenosis and endometritis is cured by treatment, as a rule, the dismenorrhœa disappears. Menorrhagia or metrorrhagia is often associated with salpingitis, but I think it will most frequently be found to be due to vascular changes in the lining membrane of the uterus, and a thorough curetting with a good instrument may effect a cure, although great care must be exercised in preparing the case for operation lest the salpingitis be so disturbed as to start up peritonitis.

Sterility is the rule in salpingitis, and when both tubes are affected, which is usually the case, it is incurable, but when only one side is affected and the proximal end of the tube of the diseased side is closed, pregnancy is