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Pelvic Inflammation.

READ BEFORE THE DETROIT MEDICAL AND LIBRARY ASSOCIATION BY HELEN WARNER, M. D.

The history of pelvic inflammation has been written almost entirely within the past thirty years. There seems to be some difference of opinion as to the knowledge of this affection actually possessed by the ancients. Simpson finds a very good description of pelvic cellulitis in the writings of Paul of Egina, and another in those of Actius, while Nonat thinks that Paul, at least, refers only to an inflammation of the posterior wall of the uterus, and quotes the following passage in proof of his assertion: "Posteriore uteri parte inflammata in ombilico potissimum cum tumore infestat." But I fear that M. Nonat's eagerness to vindicate the originality of his own investigations biased him somewhat. It seems evident enough that, though the Greek author may not have understood the pathology of the affection he was describing, it was nothing else than peri-uterine inflammation; for inflammation affecting the posterior walls of the uterus alone was in the first place rather forced, and in the second, could hardly, at least in the non-puerperal state, give us a tumor rising to the umbilicus.

But, whether or not Paul of Egina understood the pathology of peri-uterine inflammation, no such wisdom enlightened the minds of the men who came after him. As late as 1743, M. Puzor, in a treatise on obstetrics, much esteemed at the time, ascribes the tumefactions of the broad ligaments, so often noticed

in puerperal women, to collections of milk, which he considered as peculiarly liable to take on inflammation and degenerate into pus. Even Van Swieten and Antoine Petit held this singular doctrine. The milk theory was exploded near the commencement of the present century, but it was not till between 1840 and 1850 that pathological ideas on the subject became at all clear, if, indeed, they can yet be said to be so.

When attention was first drawn to peri-uterine inflammation, it was considered principally in the puerperal condition. Marechal de Calvi, whose memoir on the subject seems to have attracted great attention, published fifty cases, of which forty-nine were puerperal. Drs. Doherty and Churchill, in their articles in the *Dublin Medical Journal*, 1843 and 1844, among the earliest English articles published on the subject, have, out of twenty-four cases, twenty-two puerperal. Dr. Lever, in a paper in Guy's Hospital Reports, 1844, published nine puerperal cases. Indeed, Henry Bennett, writing as late as 1852, in the third edition of his work on Uterine Inflammation, seems to labor under the impression that he is original in describing inflammation of the pelvic cellular tissue in the non-puerperal woman.

In France, Nonat was the first who gave special attention to pelvic inflammation in the non-puerperal state. He directed his attention exclusively to the cellular tissue, especially that lying between the folds of the broad ligaments and around the neck of the uterus, between the peritoneum and the vagina. He by no means denies the possibility of a peritonitis confined to the pelvis, but he thinks it rare, and always secondary to an inflammation of the cellular tissue. This theory was resolutely combated by MM. Bernutz and Gonfil, who claimed that the cellular tissue rarely, if ever, inflames; that the so-called cellulitis is really a peritonitis, confined to the pelvis. They substaniated their doctrine by two or three *post-mortem* examinations of cases supposed during life to be cellulitis, but in which the peritoneum was found to be alone involved. One of these cases derived additional weight from having been for a time under the care of M. Nonat himself, and diagnosed by him as a case of cellulitis. Owing to the great influence of MM. Bernutz and Gonfil, the doctrine of "peri-uterine

phlegmon" was received with more reserve in France than in either Germany or England. Courty, in a very exhaustive and able article on pelvic inflammation, considers cellulitis, though demonstrated, as yet very rare in comparison with inflammation of the pelvic peritoneum. Most gynæcologists have chosen a middle course between the extreme views of these teachers; have accepted both, giving, according to their several inclinations, prominence to one or the other species of pelvic inflammation, but, in the effort to discriminate between them, often contradicting each other, and overwhelming the student or young practitioner, anxious to make an accurate and careful diagnosis, with great perplexity.

To illustrate, Dr. Thomas, perhaps the most popular authority in this country on gynæcology, and one who, whatever may be said of the accuracy of his views, rarely fails in expressing them clearly, has tabulated the points of differential diagnosis between pelvic cellulitis and peritonitis as follows:

Cellulitis.	*Peritonitis.*
1. Tumor easily reached; generally felt in one broad ligament; may be felt above the pelvic brim.	Board-like feel to the vaginal roof. Tumor very high, only felt in the vaginal cul de sac; does not extend above the superior strait.
2. Marked tendency to suppuration.	Suppuration rare.
3. Abdominal tenderness in one iliac fossa.	Abdominal tenderness excessive above the brim.
4. Tumefaction laterally in the pelvis.	Tumefaction near or upon the median line.
5. Tendency to monthly relapse not marked.	Tendency to monthly relapse very marked.
6. Pain severe and steady.	Pain excessive, often paroxysmal.
7. Facies not much altered.	Very anxious.
8. Nausea and vomiting not excessive.	Nausea and vomiting often excessive.
9. Not accompanied by tympanitis.	Always accompanied by tympanitis.
10. Uterus fixed to a limited extent.	Uterus immovable on all sides.
11. Not necessarily displaced.	Always displaced.
12. Cause. Parturition, abortions, operations on the pelvic viscera.	Diseases of the ovaries, gonorrhea, exposure during menstruation fluid in the peritoneum.

Now, this differential diagnosis has the fallacious appearance of being so clear that the most careless observer could hardly confound the two conditions; but let me compare it first with the opinions of other authors to whose works I have access, and

secondly, with the notes of five cases of pelvic inflammation in non-puerperal women, which occurred under my own observation. Simpson speaks of the board-like hardness in the roof of the vagina which Thomas gives as a diagnostic sign of peritonitis, as a symptom of cellulitis, and ascribes it to the effusion of lymph between two layers of fascia. He also says that the tumor is commonly felt in one or the other iliac fossa, it may be in the median line. He ascribes the cases largely to exposure during menstruation. He thinks the symptoms of the two inflammations nearly identical, only that the peritonitis is much the graver of the two affections.

Schroeder, of Ziemssen's Encyclopedia, agrees with Thomas in the main, but thinks that, though the tumor in pelvic peritonitis is generally small and flat, it may attain to enormous size; and gives two cuts, in each of which the tumor rises at least as high as the umbilicus. Aran, on the other hand, says distinctly that though small tumors may be due to engorgements of the cellular tissue, all large, inflammatory tumors are owing to peritonitis. Courty is equally explicit. Never, he says, has an inflammatory tumor of any considerable size been formed in the pelvis exclusively at the expense of the peri-uterine cellular tissue. The autopsies have shown that they result almost always from an inflammation more or less extensive of the peritoneum itself.

He has the grace to acknowledge that the diagnosis between the two species of inflammation is extremely difficult, and gives one diagnostic symptom of cellulitis which I have never seen either in any other book, or at the bedside in that connection, œdema of the vagina and vulva.

The first case I have to offer was a Mrs. W., æt. about 47, but still menstruating; a widow. Had been ill when I saw her about four weeks with nausea, vomiting, slight fever, and great abdominal tenderness; the exudation was first felt to the right of the uterus, but soon spread over the whole pelvis, fixing the uterus and pressing it low down in the pelvis, the roof of the vagina being as solid as plank. The temperature varied between 99 and 102½; the pulse between 80 and 90. There was a good deal of prostration, profuse night sweats, but no formation of pus, and no tumor

felt above the pelvic brim. The case lasted in all about ten weeks. I examined her about three months after she was able to be out, and found the uterus perfectly movable, no trace of the exudation remaining. This case might pass very well for a case of pelvic peritonitis, according to Thomas, except that the exudation was felt low in the pelvis, that there was no tendency to relapse at the menstrual periods, and no adhesions remained.

Case II.—I only saw once, in consultation, for the purpose of making the vaginal examination, to which she objected from the attending physician. She was a young married woman, about 25. Had been ill for some time, and for several weeks had passed pus from the rectum. There was the same board-like hardness of the vaginal roof and fixation of the uterus, which was high in the pelvis. An abscess had formed behind the uterus, which discharged by a free opening into the rectum. The patient was ill for months, but finally recovered. No cause could be assigned for either of these two cases.

Case III.—Was a young married woman, nullipara, who had suffered before marriage from antiversion and endometritis. The attack followed in her case a pretty free division of the cervix by Dr. Sims, it being the second time she had submitted to the operation. She came home within two weeks of the operation, and was taken ill almost immediately. When I saw her she had been ill about two weeks. The right iliac fossa was considerably tumefied, and the exudation could be distinctly felt by external palpation alone. There was great distress on defecation and micturition. Tympanitis was very marked, and added greatly to the discomfort. There was some nausea and vomiting; moderate fever; the temperature never rising above 102.5. The uterus was forced low down in the pelvis, exquisitely tender, and surrounded by a firm collar of exudation, like that figured by Dr. Barnes, in his article on Pelvic Inflammation. A hardened mass filled the pelvis on the right side, rising into the iliac fossa, and forming the tumor felt externally. The exudation was firm, but had none of the board-like hardness of the first two cases. There was marked tendency to relapse at the menstrual period. The case lasted about six weeks; a catarrh of the uterus remained, which yielded

very slowly to treatment. There were no adhesions. This case illustrates more perfectly than either of the others the difficulty of diagnosis. The traumatic cause, the position and consistency of the swelling, and the lack of adhesions, point to cellulitis; the tympanitis, the great abdominal tenderness, the tendency to recur at the menstrual period, to peritonitis.

CASE IV.—Had two attacks under my observation, and I am inclined to think had had at least one, and perhaps more, before I saw her. She was a married woman, aged 35; had had four children. When I first saw her she was suffering from endometritis and engorgements of the neck, with a profuse acrid discharge, containing a good deal of blood. The neck of the womb was very sensitive; the body was held down, but not very tightly, by adhesions on the posterior surface. There was a small, but exceedingly tender swelling on the right side of the uterus. In the course of the treatment this disappeared entirely, but about four months after, when she had nearly recovered from the uterine difficulty, she took a violent cold, in consequence of lying down to rest when fired and overheated, in a room imperfectly warmed. When I next saw her she had considerable fever; temperature 103, pulse 112. Complained of intense pain on micturition and defecation, and constant and severe pain in both iliac fossæ—more severe in the right. On examination, I found tumors on each side of the uterus, located evidently in the broad ligaments, the one on the right side being somewhat the larger—about the size of a small orange, and, though not fluctuating, not very hard, rather doughy in feeling. The menses came on within a week from the commencement of the attack, and seemed to relieve rather than aggravate it. At the close of the next menstrual period every trace of exudation had disappeared. So, the uterine disease being nearly removed, and no trace of the pelvic inflammation remaining, I ventured to insert a pessary, a block tin ring of Sims', bent into the shape of a Rodger's double lever, with the design of putting the adhesion on the stretch and raising the uterus as nearly as possible to its proper place in the pelvis. I instructed the patient to remove the instrument if she felt any inconvenience from it, and saw her again the third day. I found

that the pessary had been tolerated very well for thirty-six hours, but after that time some discomforts had been experienced, but, knowing that I intended visiting her in the morning, the patient had put off removing the pessary till my arrival. I found her suffering some pain, feverish, complaining of creeping chills. On examination, the uterus was found somewhat sensitive; on the right side of the uterus, about the point of the insertion of the broad ligaments, there was a point of induration, not larger than a bean, but exquisitely tender. In spite of antiphlogistic measures, the inflammation developed. The tumors appeared as before on both sides of the uterus; the one on the right disappearing more slowly, and seeming to recede from the uterus toward the side of the pelvis as it decreased in size. After it was fully developed it was not especially sensitive. The tumefaction did not entirely disappear till after the second menstrual period. The menstrual discharge during these attacks was very free, though not amounting to hemorrhage, and produced marked relief. The diagnosis from other affections of the pelvic organ is comparatively easy, though there are some cases where there might be difficulty in distinguishing between a subacute inflammation and a commencing tumor of the ovary or broad ligaments.

A woman came to me about a month ago, complaining of pain on micturition, and mentioned incidentally that she had suffered pain in the right iliac region for two or three days past. I saw her about six months ago, and she assured me that she had been unusually well in the interval, till within two or three days. I found on examination a tumor, perhaps two inches in diameter, occupying the right side of the pelvis, free from the uterus, and very slightly sensitive, exactly similar in feeling to the tumor in case No. 4, when the process of resolution was well under way. I don't think it had any connection with the pain on micturition, as the patient was subject to irritation of the bladder on taking cold, and had several times consulted me on that account. There was not the slightest fever. I confess myself in doubt about the diagnosis. I gave the woman an infusion of buchu for the irritable bladder, advised her to paint her side where she had the pain with tinct. iod., and said nothing to her about the tumor, consid-

ering that if it was inflammatory it was in process of resolution, and would probably disappear of itself; and if ovarian she would have time enough to worry about it after it began to trouble her. I have heard nothing from her since, and conclude she has had no further trouble.
