1859.

Thomas B. Lowen
Pelvic cellulitis.

or

Inflammation of the Cellular Tissue of the Pelvis.

By

Thomas C. McGown.
The subject of the following Essay is one of great importance, and one which has not as yet, sufficiently attracted the attention of medical men. I have endeavoured to give an outline of the information known regarding "Pelvic Cellulitis" at the present time, without pretending to any originality. The authorities I have consulted are duly acknowledged.

While offering this Essay, I am conscious of its many imperfections, and deficiencies; perhaps partly due to the unsatisfactory state of my health for some time past. Hoping, therefore, that on its criticism, indulgence will be granted.

Thomas C. McGown
Index

Pelvic Cellulitis Page 1
Anatomy of Parts Concerned — 3
Morbid Anatomy — 5
Causes — 8
Symptoms — 12
Terminations — 16
Diagnosis — 20
Differential Diagnosis — 24
Prognosis — 27
Treatment — 28.
Pelvic Cellulitis.

Pelvic inflammation appears to have been known as early as the 7th Century to Paulus Egbertus. It subsequently fell into neglect until the middle of last century when it attracted the attention of several continental writers especially Siracus, who erroneously attributed it to "metastatic deposit of milk." Pelvic Cellulitis again ceased to attract attention, most of the systematic writers overlooked it entirely, or merely alluded to it as an occasional complication of puerperal fever, until it once more attracted notice in recent times. In France M. Marchal d'Orlai in 1844 wrote a compendium of all that was known of it at that time. In this country various authors have written on it especially Doherty, Churchill, Lever, Kennet, Simpson, Purchase, & Witt.

* Sydenham Society, Trans. of his Works by Francis Owen Vol. II p. 385
Pelvic Cellulitis has been variously described by different authors, and under different names—e.g., "Pelvic Abscess," "Abscess of the Uterus," &c. It arises induced by irritation on the right side from the Caput Ovarii Oli; it forms the Perityphlitis* of Bumce & others—but at the present time it bears the more correct designation of "Pelvic Cellulitis," as it often ends in resolution without the formation of an Abscess.

Pelvic Cellulitis may occur at almost any period of life. "I have seen it (says Prof. Simpson) at many different periods of life, from six years up to sixty." It has generally been treated of in its connection with the placental state; it may, and often does occur independently of pregnancy or labour.

Out of 23 cases mentioned by Churchill 21 were placental

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<td>52</td>
<td>56</td>
<td></td>
<td>West</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>17</td>
<td>Bell</td>
<td>6</td>
<td></td>
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† Obstetric Works Vol. 1, p. 211.

(1) Churchill, Simpson, Kennet, & West & Bell (Med. Gazette, 1864 & 1865)
It would be difficult to obtain any satisfactory estimate as to the comparative frequency of the puerperal and non-puerperal cases. As the latter are generally less severe, many may end in resolution without attracting much attention, and without their true character being ascertained.

In the puerperal form, the period of occurrence after labour varies much in different cases; in some cases from 3 to 10 days after delivery, in others not until the lapse of 2 or 3 weeks, or even more, according as the inflammation had its primary origin in the cellular tissues, or extended thence from the neighbouring textures.

Anatomy of the Parts concerned. - The peritoneum, in the female, after covering the posterior surface of the bladder, is reflected on the uterus, covering the anterior surface of its body; its posterior surface (with a small part of the vagina) and is then reflected on the rectum. As it passes from

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* Churchill (Dublin Medical Journal 1844 - Midwifery p. 399
+ Murphy's Midwifery
the anterior to the posterior wall of the uterus. The peritoneum forms two wide folds which by their juxtaposition constitute the Broad Ligaments of the uterus. These folds of peritoneum are everywhere closely adherent to the muscular structure of the uterus except on the narrow lateral margin of that organ. The folds of Broad Ligament are separated from each other by a quantity of Cellular Tissue (and Womb, Fallopian tubes, & round ligaments of uterus). This Cellular Tissue is connected with the to some extent distinct from the other Cellular tissue which exists abundantly along the lining walls of the pelvic cavity, it between the uterus and vagina, and the bladder, between the uterus and the rectum, and between the rectum and the sacrum.

We have thus in the cavity of the pelvis, adjoining the uterus - above the pelvic fascia (which form a perfect floor to the pelvis), between the peritoneal folds, but external to the peritoneum - a large quantity of Cellular tissue - a tissue peculiarly liable to "Inflammatory Action."
Morbid Anatomy. - The cellular tissue I have just described, is very liable to become the seat of inflammatory action. That part of it, however, which is most commonly affected, lies between the layers of the "Broad Ligament." Next in frequency, according to West and the cases where the cellular tissue between the uterus and rectum is affected, while those, in which the tissue between the uterus and bladder is attached, are much rarer. *

When the seat of inflammation is between the folds of the Broad Ligaments, the tumour generally adheres to the uterus, spreads rapidly, and becomes attached to the side of the bone, where it exactly simulates an "Osseous Tumour" and can hardly be mistaken for any other - it being of bone hardness. It sometimes spreads round the uterus and passes to the other side of the pelvis, and the uterus seems sealed. Sometimes we have disconnected independently with the uterus, or with the pelvis, or, we may have a free tumour unconnected with the uterus or with the pelvis, as is the case with the Ovaries. As the

* West on Diseases of Women part II page 6
Tumour is prevented by the Pelvic fascia from descending, it therefore ascends and forms an
slight tumour of one or the other side. Occasionally it will run very rapidly across and communicate
with the deposit between the broad ligaments, so that when opened above the finger may be passed down
to the space between the broad ligaments. At other
times it perforates the different fasciae, and attacks
the various tissues around and contained in these.

Inflammatory exudation is thrown out around the
Nerves passing to the inferior extremities, causing
severe Neuralgia; also causing pressure on the veins
and in some instances obliterating them. We may
leave it (tumour) elevating the peritoneum, but it
rarely perforates this membrane, because the
peritoneum lining the pelvic cavity is much
thicker than that covering the intestines or other
Abdominal viscera. It is so reinforced by strong
fibrous tissues that it offers effective resistance in
most cases to perforation by a pelvic abscess. In
the superficial and worst forms of the disease, the
Inflammation has a tendency to extend to the

peritoneum covering the pelvic viscera, but in such cases the uterus itself is generally considerably complicated. The peritoneum, however, has not the same tendency to become inflamed in cases of inflammation of the pelvic cellular tissue, from continuity of texture, as the cellular tissue has in cases of suppurative peritonitis. Inflammation is sometimes simultaneous on the broad ligaments, uterus, and ovaries, probably explained by the fact of the nerves and blood vessels ministering in common to these structures.

**Constitution of Tumour.** The tumour in its early stage is generally found to contain a serous, or serofibrinous fluid, and may remain so for 2 or 3 weeks. In this state, it is amenable to absorption, and under suitable treatment may rapidly disappear. But a higher grade of the inflammatory process may be reached, when the tumour is found to contain aggregable lymph of a very hard consistency and completely solidified; or it may pass on to suppuration. On examining the tumour in this stage, it is

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* Dr. J. H. Bennet on the Uterus — page 54.
† Bindell on Obstetrics.
found to contain purulent matter, which, if not evacuated by the hand of the surgeon, may discharge itself in various ways (see Page 17 et seq.)

Here, many cases in practice, where the nature of the tumour is a subject of doubt. In these cases recourse should be had to the exploring needle.

Causes.—Pelvic Cellulitis has been produced by a variety of causes—of these Cold appears to be one of the most frequent, it acts reflexly through the medium of the nervous system. Cold may also act secondarily by producing suppression of the Menstrual secretion, Lochia, or Milk. These secretions, when suddenly suppressed from whatever cause, are fertile sources of inflammation of the Pelvic Cellular tissue, and of the organs which act in sympathy. The sudden suppression of a secretion giving rise to inflammation is a well known fact in Pathology. Many examples of it might be adduced, as in Orchitis following the sudden suppression of the Gonorrhoeal discharge; or the sudden suppression of the Cysticous secretion often
causing pneumonia or other internal inflammations. Other examples might be adduced to the same effect." Pelvic cellulitis has also been produced by Blows Falls. It has followed operative interference with the uterus and its appendages (as well as with the bladder in the male). It has followed the use of Caustics as Vinna Pisto, in hypertrophy of uterus, * the apparently rarely. Pelvic cellulitis occurs most frequently after delivery, or after abortion. It occurs very frequently after labour terminated naturally. Of 37 cases following delivery mentioned by West, in only 4 of them was the labour protracted, in none was instrumental interference necessary. It is not necessarily due to any mismanagement on the part of the Puerperal attendant. The child born may be small or large; but, where a want of proportion exists between the child's head, and the Mother's pelvis, and when labour is protracted or terminated artificially, or after proternatural, complex, or forcing delivery. The Cellular tissue is more likely to be severely bruised, and

Oldham, Guy's Hospital Report 1848

West on Diseases of Women p2, page 4.
Inflammation consequently lighted up. According to Lexer, the part affected will generally be found to correspond with the position occupied by the focal deposit; being more frequent on the left side. Pelvic Cellulitis has been caused also by continuity of texture from Metritis, Sepsis and Peritoneal Peritonitis. It sometimes comes on as consequence of a deranged state of the alimentary canal accompanied with cold—also from irritation extended from the Os pudendum.

I have given a brief statement of the various causes which have given rise to Pelvic Cellulitis. There are, however, cases which have come on without any appreciable cause.

The following table from West* will show the influence of labour &c. as causes of Pelvic Cellulitis:

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* Cary's Hospital Reports. Vol 6 page 219.
\[\text{West on Diseases of Women, Vol. II. page 4.}\]
<table>
<thead>
<tr>
<th>Parts affected</th>
<th>After Delivery &amp; Abortion</th>
<th>After Inflammation of Uterus</th>
<th>After Inflammation of Oviducts</th>
<th>Independent &amp; Septicemia, Few Cases</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right side without abdominal tumour</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>with V. suppurating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>with v. suppurating &amp; with left ovid.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Left side without abdominal tumours</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>with V. suppurating</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>with V. suppurating &amp; with left ovid.</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Both sides without abdominal tumours</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>with V. suppurating</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>with V. suppurating &amp; abscess in rect.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Disease between uteri &amp; rectum</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>with V. suppurating</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Disease between uteri &amp; bladder</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td>with V. suppurating</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>with V. suppurating &amp; with ext. ovid.</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>External Peritonitis alone suppurated</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

| Totals: 27 | 10 | 6 | 1 | 1 | 6 | 52 |
Symptoms. - In some cases the disease is very
mastic and insidious in its progress: In such
rare cases, the patient sometimes going out at the end
of a month; but on enquiry, it will be found
that she has not been as well as after previous
confinements. In other cases, the symptoms are
more active, and give rise to considerable constitutional
disturbance. The principal symptoms are:

1. The presence of a Tumour. - The tumour is generally
rapid in its progress. Two or three days after the
symptoms have begun, on examination a fulness
may be felt in either iliac region, which goes
on increasing in size. The situation of the
tumour varies in different instances -- sometimes
it is deep in the pelvic cavity, between the
Uterus and the Rectum; or between the Uterus and
the Bladder. In such cases it cannot, in
general, be detected through the abdominal parietes,
but by examination per Vaginae, or per Rectum.
When seated, however, as is most frequently the
case between the folds of the Broad Ligaments, it
can generally be so detected. The tumour is
generally firm from its earliest stage, adhering
firmly to the pelvis. The presence of this tumefaction is invariable, and is characteristic of the disease. It may be found completely above Poupart's ligament, sometimes completely filling one iliac fossa, and even extending upwards as high as the umbilicus, or it may only reach Poupart's ligament, protruding the groin, and appearing as a to those parts. In the former case above Poupart's ligament it is more easily moved, and is less painful than in the latter. When suppuration has taken place, the tumour loses much of its hard consistence, when fluctuation may be detected.

The presence of this tumefaction is always accompanied by other symptoms viz:—

II. Pain.—Pain is a constant attendant. It is first referred vaguely to the lower part of the abdomen; at length with the growth of the tumour it becomes more localized. Pressure on the tumour is invariably accompanied with increase of the pain. The amount of pain varies much according to—

1. Position of tumour.—It is less painful when above the pelvis than when firmly impacted.
among the viscera in the pelvic cavity (between
the uterus & rectum, or, between the uterus & bladder)
but, more especially if the pain be severe, when the
pelvic fascia has become perforated, and
inflammatory exudation has been thrown out
around the nerves passing to the lower extremities
then will severe pains be found shooting along
the course of these nerves resembling sciatica
(for which it has been mistaken).

2. State of Tumour. - Tension is the main cause
of pain. - Pain therefore increases with the growth
of the tumour (modified of course, by its position).
The intensity of the pain decreases when the
inflammatory process has reached the supplicative
stage. - The position of the tumour gives
rise to other symptoms viz:

III. Dysuria, Tenesmus & Constipation. - When the
tumour occupies a part of the pelvic cavity
(between the uterus & rectum or sacrum - or between the
uterus and bladder) it interferes more or less
with the functions of the viscera therein contained
either from the irritation produced, or from the
effects of the mechanical pressure exercised.
I ncreasus, and the frequent desire to urinate, are given rise to, or the functions of these organs may be still further impeded. Defecation may be interfered with from the pressure, or retention of urine may result. (This tumour between the Rectum & Bladder in the male may give rise to the same results. Retention of urine may be simulated. The abscess may so compress the bladder, as to prevent its distention and consequently urine is always passing away from the collapsed tissues, while the abscess is forming a dull hypostatic swelling, resembling a distended bladder.)

IV. Fever. - In some cases it precedes or accompanies the first local symptoms; in others, its advent is at a later period, sometimes it is almost confined to the evenings. Definite symptoms are generally ushered in by a rigor. But especially it is when suppuration has supervened that the fever becomes aggravated.

One such case is narrated by West in diseases of Woman III. page 15.

† Miller's practice of Surgery, page 451.
When there are recurring exacerbations - the tongue becomes loaded, the appetitie bad, the skin hot, and the thirst considerable. The pulse is from 90-100. Evacuation of the body takes place to a considerable extent, and even necrosis may supervene.

Terminations

( I. Resolution

II. Abscess)

I. Resolution. - This most frequently occurs in cases where the tumour is above the pelvic brim and circumscribed. Resolution may take place suddenly or very gradually, spontaneously, or with the aid of drugs. It may be imperfect or complete. The more recent and slight the change, the more likely is resolution to be rapid, spontaneous, and perfect, because when the inflammation has been slow, time has been afforded for the fibrinous deposition to assume a solid and organizeable form, & therefore less amenable to absorption than in the fluid or semifluid condition in which it
is found soon after inflation. When the fibrous
inflation has become hard it cannot be again
reabsorbed without its being first reduced to the
molecular form, and under any treatment considerable
time is required for this to take place.
As resolution proceeds, the tumour parts with
its hardness; the pain diminishes pari passu with
the diminution of the tumour, until at length both
disappear, after a varying interval—from a
few weeks to several months, or it may be years.
2. Suppuration. When suppuration has taken
place, the febrile symptoms become aggravated,
and on examination, a sense of fluctuation may
be felt through the abdominal parietes, or per
Vaginam or Rectum, according to the seat of the
Inflammation. In this stage Resolution can hardly
be looked for; if left to itself, the fluids will
generally find an exit in one of the following ways:-
1. Through Vagina or Uterus. This is one of the most
frequent, as it is also the most favourable mode
by which the pus can find a way of escape. The
aperture of escape is generally small, just below
the Corvixithei. The escape of pus through the

Uterine Walls is of rare occurrence, owing to the firm attachment of the peritoneum to the muscular fibres of the Uterus, & the thickness of the Uterine Walls themselves.

2. By the Intestinal Canal. - This is also a frequent route by which the pus escapes. In cases where the Cellular tissue, between the folds of Broad Ligament, or, between the Uterus and Rectum, is the seat of inflammation, the pus most frequently bursts into the Rectum, low down within the internal sphincter. It generally gives rise to considerable irritation of this canal, and symptoms resembling those of Dysentery.

3. By the Bladder. - This is somewhat rare in its occurrence, which is accounted for, not by thick peritoneum, but by the loose attachments of the Bladder, and the distance between the true and false ligament of the Bladder.

4. Through the Abdominal.parities. - This is also comparatively rare, and not generally until it has formed other opening.

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† West on Diseases of Women part 2.
5. Into the Peritoneal Cavity. - This is very rare, owing to the dense fibrous structure which reinforces the peritoneum in the pelvic cavity. (Crichton)

6. Into surrounding Cellular Tissue. - Sometimes the abscess will open by two or more of these ways successively, or at the same time. It has formed openings both by the Uterus & Cæcum,* or sigmoid flexure of Colon (Simpson). The collection of pus formed between the Uterus & Bladder has opened in both of these ways. In another case, it opened both into the Rectum and Bladder, without affecting the Uterus and the Vagina. - Then such double perforations, with the escape of pus, degenerate into the Chronic state; they lead to the formation of deep pelvic fistulae - Utero-Intestinal, Vesico-uterine, & Vesico-Intestinal (fistulae). Interesting cases of these kinds of fistulae have been narrated by Prof. Simpson.†

Perforation of the abscess generally takes place during exertion - as a fit of coughing, or the act of

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* Cundham, London Medical Gazette 1833-34.
† Obstetric Works Vol I page 232.
‡ Medical Times & Gazette Sept 1854 page 239.
defecation. In a case mentioned by "Dick," it was
to the jolling of an omnibus. In
some cases the perforation and escape of pus is so
latent, when passing by stools, that it might escape
observation altogether, unless the patient's attention
were directed to it.

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Diagnosis.— The diagnosis of Pelvic Cellulitis is
not in general attended with much difficulty.
No single one of the symptoms which have been
enumerated (Page 12 of leg 148) is— the presence of a tumour,
or of pain, of diarrhoea, or of tenesmus— or the Constitutional
symptoms, can be considered as pathognomonic of this
affection. Any one of them may rank among the
symptoms of other affections. When, however, all or
most of these symptoms present themselves in the
same case, there is at least, strong presumptive
evidence that the patient is labouring under
"Pelvic Cellulitis"; and more especially is this the
case if the patient has not made a satisfactory
recovery from the effects of a recent delivery.
Most of our dependence ought to be placed
on the physical means of diagnosis. To various of these I shall now briefly allude:

1. Externally Examination. If between the folds of the broad ligament, the tumour, hot and painful to the touch, may be felt in one or other blad region; it is not in general very distinctly circumscribed. On percussion over this region, a dull sound is elicited. If the patient's thighs be flexed on the trunk; on manipulation, the relaxed abdominal walls will be found to glide over the tumour. When the suppurative stage has been reached, a deep-seated sensation of fluctuation may also be felt.

2. Examination per Vaginae or per Rectum. When the seat of inflammation is deep in the pelvic cavity, between the folds of broad ligament—between the uterus and rectum, or the uterus and bladder. On examination, the vagina is found to be hot and painful to the touch, and on one or the other side, or both, or at its upper part, a hard painful swelling may be detected. On attempting to push back the vagina, unusual resistance is offered,
& the Vaginal Cul de Sac, which in the healthy female may be pushed before the finger for an inch or two on the side of the uterus, has disappeared, whilst a painful, hot, and indurated swelling rests on the Cervix and body of the uterus, very different from what is found on the other side, provided there be inflammation on the one side only, which is most frequently the case. The swelling, if considerable, may push the uterus to the other side of the pelvis. — The state of the pelvic cavity may in general be ascertained with great accuracy, more especially when examination is made simultaneously, both per Vaginam and externally through the Abdominal walls. In the natural state of the parts, the finger, introduced per Vaginam, may be approximated within a short distance of the hand placed over the abdominal parieses. When, however, the cellular tissue described is inflamed, this cannot be accomplished, but the tumour, when pushed from the Vagina, impinges on the hand placed in apposition externally.
3. **Uterine Sound.**—By its use we can generally ascertain whether or not the tumour is connected with the uterus, thus demonstrating whether the tumour belongs to the uterus itself, or is independent of it. (It is only in cases where there is no organic connection subsisting between the tumour and the uterus, preventing their mobility, that this can be accomplished.)

The uterine sound is also necessary in distinguishing between retroversion of the uterus and the tumour, when it exists between the uterus and rectum.

4. **Exploring Needle or Thread.**—This means of diagnosis in most cases may be used almost with impunity. Prof. Simpson has found it useful in detecting the nature and contents of various kinds of tumour when no other means of diagnosis was sufficient. Enough of the contents of the doubtful, will generally enter the instrument, to enable the observer to determine its nature with the aid of the microscope. If pus be found, the nature of the tumour is at once established.

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* Simpson's Obstetric Memoirs Vol. 4, Page 36 * 94
Differential Diagnosis.

1. From Metritis. - In Metritis the pain is generally greatest in the median line, whereas in Pelvic Cellulitis the tumour and pain are felt generally in other fluid region. It may further be distinguished by examination per vaginam and rectum.

2. From Uterine Haematocele. - Uterine Haematocele generally bears a marked resemblance to Pelvic Cellulitis, and may be mistaken for it. The principal points of difference are:
   a. Uterine Haematocele forms more rapidly.
   b. It is softer at first, and becomes harder as the more fluid portion of the extravasated blood becomes absorbed by the vessels.
   c. It is not so painful to the touch.
   d. There is not the same induration and thickening of the vaginal walls.
   e. It is not attended with the same constitutional disturbance.

The opposite of all this generally holds true in Pelvic Cellulitis. If, however, doubt still remains, it may be removed by employing the proved needle. Uterine Haematocele from the irritation produced by it has given rise to Pelvic Cellulitis.
3. From Retrusion of Uterus. - Sometimes when pelvic cellulitis is between the Uterus and Rectum, it may be mistaken for Retrusion of the Uterus. The direction of the Uterine sound, when introduced, will show that the Uterus is not retroverted. While the accompanying symptoms together with the use of the exploring needle, will unfold the true nature of the tumour.

4. From Abscess of the Abdominal Parietes. - The patient should be placed in the recumbent position, with the limbs flexed on the trunk, so as to relax the Abdominal Walls (if the pain on manipulation be great, the patient may be advantageously placed under the influence of Chloroform) which will be felt to glide over the tumour, which is not the case in Abscess of the Abdominal Walls. - When the pelvic Abscess, however, is far advanced and pointing externally through the Abdominal Walls, the diagnosis is very difficult.

5. From Sciatica. - The Neuralgia occasioned by Pelvic Cellulitis has been mistaken for Sciatica. When, however, a careful examination has been made, this error is not likely to occur. The presence of a tumour in the pelvis, with the Constitutional symptoms, will show the true nature of the case.
6. Retention of Stools. - Retention of fecal matter in the rectum, or sigmoid flexure of Colon, has been mistaken for Pelvic Cellulitis. In nervous females considerable Constitutional derangement, from fecal collection, is sometimes induced; nevertheless, the diagnosis is not generally very difficult. On enquiry it will be found that there has been constipation of the Bowels, or, if, on the administration of an enema, or a smart Cathartic, the tumefaction be found to disappear, the true nature of the case will be at once revealed.

7. From Disease of the Hip-Joint. - The patient may be found lying on the back, or on the sound side, with the thighs flexed on the Abdomen, with the limb of the affected side resting for support on that of the sound side, and rotated inwards as in Hip joint disease, whilst the pain is referred to the knee. With the symptoms and means of diagnosis already enumerated (as: the presence of a pelvic tumour, on examination externally, or per Vaginum and Rectum, and also by using the grooved Needle, at our disposal), there will be no difficulty in arriving at a correct conclusion.

* Phoent, "Dublin Medical Journal," Nov. 1853, p. 464
+ So. and in "Mediciæ Societæ Gazettæ." 1854, p. 163.
St. Bennett in his work has endeavoured to draw a distinction between the purulent and non-purulent cases of Pelvic Cellulitis. The drawing of such fine distinctions as those brought forward by him, would seem to be unnecessary refinement without any useful application. The difference between the two being to all appearance, in point of the severity of the symptoms; the purulent variety being generally the more severe.

Prognosis.—The prognosis is for the most part favourable. When Abscess has formed, the patient often lapse into Nectie from the profuse discharge which takes place; but as the cause of irritation is not persistent, they generally recover as the Abscess diminishes in size. In some cases the patient dies from the exhaustion produced by the continuance of the discharge.

When the Abscess opens into the peritoneum or the bladder, the prognosis is exceedingly unfavourable.

Bennet on the Ulcers page 54.
Treatment. — The treatment to be followed is
1. To promote resolution of the tumefaction; failing that—
2. To promote suppuration & evacuation of the matter.

1. To procure resolution. — It is only in the earlier stages of the tumour, when it consists of a serous fluid, or coagulable lymph, that resolution is to be looked for. Our first duty in treating the patient is to prevent the access of cold and other exciting causes — to ensure rest and freedom from all bodily and mental excitement. The bowels should be cleared out by means of a mild Cathartic, namely, or a mild laxative, such as Castor Oil, administered by the mouth. — (The use of powerful Cathartics is to be avoided, as the irritation thereby produced on the lower part of the intestinal tube, might, from its nearness to the seat of the inflammatory action, produce aggravation of the symptoms)

The patient must also be put on Antiphlogistic diet. And thus we are in a favourable position to proceed with the directly remedial means. — Those termed Antiphlogistics, of which, I shall now briefly allude to a few of the more important.
Depleting Means. - In employing these means, we must be guided by the state of the patient's strength. Bleeding should not be had recourse to indiscriminately. The following circumstances should be taken into consideration: the duration of the disease, the age and temperament of the patient, the state of the system previous to the inflammatory attack, whether plethoric or anemic. - The nearer the commencement of the inflammation, the more likely is bleeding to be followed with success. When the patient is plethoric, blood may be taken in greater quantity, but when anemic, if blood be taken, it must be sparingly; in such cases, local bleeding by means of leeches repeatedly applied will be found more effectual, and with less expense of the bodily powers. The leeches should be applied round the verge of the anus, in the vagina, or at the lower part of the abdominal wall. - A great amount of discussion has taken place at the present day as to the treatment of inflammation by blood-letting being productive of good or evil. As usual with

* Roberts. Churchill.**
the discussion of such subjects. Extreme views have been held, and fanciful theories have been propounded on both sides. As two extreme views diametrically, the reverse cannot both be correct, it might be the safer way to hold on in the intermediate course, and to bleed according to the strength of the patient; when the pulse is full and hard, blood may be taken in plenum rivo till a sufficient effect be produced, but on the other hand, when weak, blood must be taken sparingly, if at all. It is not my intention to bring forward the arguments which have been adduced in favour or condemnatory of bloodletting. Whether or not internal inflammation be cut short by the abstraction of blood, one thing is certain—that after the employment of it, the pain and other symptoms are much mitigated. A heat desideratum certainly.

Derivative treatment. — Warm fomentations, and the warm hip-bath afford much relief to the patient, as also—washes injecting into the vagina two or three times daily. Counter irritation at the lower part of the abdomen, by means of
Nitrates of silver, or tincture of iodine may also be useful. Cantharides in any form should be avoided, because not unfrequently the active principle of them becomes absorbed, and acts as an irritant on the urinary organs, producing dysuria.

Alteratives. — A considerable number of the remedies of this class have been employed viz:—

1. Mercury. — Mercury is best given after bloodletting. It should be given in the form of blue pills or one or two grain doses frequently repeated, or Colonies of 5 grain doses until the mouth becomes affected showing that the physiological action of the drug has become established; when the frequency of the doses may be diminished, giving only as much as is necessary to keep the system under its influence. Mercury appears to have the power of preventing further exudation, and also of promoting the absorption of exudation already poured out. Its use should not be pressed too rapidly, as in Belloc's Cel lulitis when the tumour contains lymphe, considerable time is required for the already hard exudation to be rendered amenable to absorption.
The use of Mercury in inflammations has been doubted in recent times. We have no direct evidence with regard to internal inflammations, but in fevers we have opportunities of witnessing its effect. Whoever has seen it used in this affection can doubt its ability — in Pileus Cellulitis it may be advantageously given in combination with opium, with the twofold view of preventing its too rapid discharge from the body and of relieving the pain.

Mercury should not be given in ulcers. In these more advantage may be derived from the employment of Iodide of Potassium or Tartar Emetic. It is also a useful antiphlogistic. It should be given in small doses of from 1/2 to 1 gram every 2 hours. It has like Mercury the power of favouring absorption, and counteracting effusion.

According to Headland, these medicines have much the same result - bloodletting weakens the force of the heart by diminishing the pressure on its vessels.

* Action of Medicines page 314
Tartar Emetic diminishes the pressure of the vessels by weakening the force of the heart. Mercury does both of these things by impoverishing the blood. — Thus all of these favour absorption and counteract effusion.

Sometimes under whatever treatment it is long before all remains of the inflammation disappear. Months or even years elapsed ere all the tumefaction has disappeared and during this time the patient is liable to relapses. These exacerbations become less frequent as absorption proceeds. (Bennet.) Frequently the inflammation advances in spite of the treatment; in those cases treatment should be with a view

2. To promote suppuration and evacuation of the matter. — When suppuration has taken place, resolution and absorption can hardly be looked for; therefore, instead of the anti-inflamatory diet and other treatment suitable for the inflammation in its earlier stage, a generous diet must be substituted to enable the patient to make way against the depressing effects of purulent discharge.
When an abscess has formed, the question arises -
whether it is to be opened by the surgeon, or left to nature? This will depend in a great measure on the position of the tumour, and its distance from the more favourable vessel by which it usually finds an exit, and the danger that might be incurred from its nearness to important structures. If attempts were made to open it artificially, then the abscess is already pointing, and if little risk be incurred, this still somewhat deep, it should be opened early, to give a course to the matter and prevent its burrowing, and, it may be, opening in some dangerous locality. If fluctuation be through the hypochondrium, then the aperture may be made in that part of the abdomen to which the tumour points. (by means of Veriæ punct. slits.) It would be imprudent to open the abscess, if the tumour be high, without having effected an adhesion between the cyst and the abdominal parietes, lest part of the contents might escape into the peritoneum, but whether opened spontaneously, or not, free exit

* Selt on Measurament of
must be afforded for the matter, to prevent the discharge becoming chronic, or the opening fistulous.

When fluctuation is plainly felt in the vagina, the abscess may be opened as recommended by Wieland. Instruct her to introduce a speculum when the abscess is soft and thin (as felt by the finger). It is to be divided at the top by a scalpel or needle, and after discharge of the pus, an oblong tent oiled is to be introduced into the opening. Afterwards she is to be put in warm baths. The ointment terepinum-aconit (Reseine) is to be applied to the opening, and cataplasmas to the pudenda till the inflammation be subdued.” After the abscess has healed an indurated state of the textures remains which may interfere with enlargement of the uterus in future pregnancies and give rise to Abortion. If the fallopian tube may become obliterated, or an ovum may be hindered in its progress, from narrowing of the tube, and extra-uterine pregnancy ensue. Or other changes may remain, interfering more or less with the functions of those parts.

Finis.


- Roberts -
Very good - little clear about 17th century.


S. M. Safdieh