Splenic Hæmorrhage Complicating Pregnancy.*

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Mrs. B., aged 31; ii-para; admitted to the Victoria Central Hospital, February 26 1912.

History. Ten days previously, whilst out walking, she was seized with severe pain in the left side and abdomen, felt very faint, was assisted to her home, and went to bed. Next day, feeling better, she got up and went about her household duties. A few days later she had another attack of abdominal pain which was not so severe and not accompanied by much general disturbance; later, on February 24, she again had severe pain, with considerable collapse, which so alarmed her friends that her doctor was called in, who found her collapsed, pale, pulse-rate 90, well filled and regular. With a history of twelve weeks' amenorrhœa, and some morning sickness, a diagnosis of ectopic pregnancy was made. She rapidly improved for two days, when again there were signs of peritoneal irritation.

February 26, she was removed to the Hospital. She complained of constant severe pain at the level of the left lower costal margin in the nipple line, and over the descending colon. She was pale, but not markedly so; the abdomen was adipose, not distended. On palpation there was very great tenderness on the left side at the level of the costal margin, and in the left iliac region.

Per vaginam. The uterus was enlarged, about the size of an eight weeks' pregnancy, freely moveable; the appendages were not felt, no sign of pelvic swelling or bulging in the fornices. No vaginal discharge, and no history of any vaginal hæmorrhage; pulse 116, temperature 99·8°F.

From the absence of blood-stained discharge, I decided against its being "ectopic," and elected to delay operative treatment until next morning. The night was restless, vomiting occurred several times, and the pain increased, together with a rise in pulse-rate.

When seen on the morning of February 27 the abdomen was distended in the flanks, which also were dull on percussion, and there were signs of a considerable fluid exudation in the peritoneal cavity. We concluded that hæmorrhage was going on, and at once opened the abdomen. On entering the peritoneal cavity free blood-stained, dark-coloured serum filled the pelvis, and a measured 40 ozs. escaped.

* Read at North of England Obstetrical Society.

The ovaries and Fallopian tubes were normal, the uterus pregnant and also normal. There was no sign of any stomach or bowel contents in the fluid or peritoneal cavity, nor was the bowel in any portion collapsed.

The incision was now prolonged upwards, almost to the ensiform cartilage, where we located the hæmorrhage coming from the neighbourhood of the spleen. Bringing the spleen more freely into view, it presented a rounded mass of partially-organized blood-clot, most markedly forming a mass on the upper surface of the spleen, firmly adherent to it, and completely hiding the spleen, except a small portion of its inner border, and apparently covered by a fibrinous capsule. The whole formed a mass twice as large as a normal spleen; a perforation of the stomach was carefully searched for, on the supposition that the hæmorrhage was adventitious; none being seen, and the hæmorrhage appearing to be entirely splenic, the vessels were ligatured and the spleen removed. The hæmorrhage ceased at once. Two pints of normal saline were poured into the peritoneal cavity and the wound sutured with silkworm gut through and through interrupted sutures.

The patient was considerably collapsed, and rallied fairly during the day; but the same evening became worse, and died of exhaustion in 48 hours after the operation.

Dr. Murphy, Pathologist to the Hospital, made a post mortem examination. Stomach, intestines, liver and kidneys were all normal; there was no sign of any ulceration or perforation of the stomach, and no more bleeding had taken place into the abdomen, so that we concluded the hæmorrhage occurred from the spleen.

Dr. Murphy reports microscopical sections of the spleen show normal splenic tissue. Dr. Leith Murray reports the spleen very brittle and difficult to cut. The pulp shows no endothelial hyperplasia. Areas of blood extravasation are present near the peritoneal surface, which is two or three times thicker than normal, but shows no active inflammatory deposit.

The hardening of the spleen before removal of the blood-clot has somewhat vitiated the search for rupture. There was no history of injury. On feeling the spleen when *in situ*, it was rounded, and felt somewhat spongy and soft; so much so, that one feared to handle it lest it would tear. The blood-clot was covered by a thin, fibrinous layer, which seemed to be splenic capsule, and if so, then the condition, in spite of the microscopical report, is surely an altered condition of spleen, with hæmorrhage into its substance, and if so, is it one of the known splenic lesions, or is it a change associated with pregnancy?

Several cases of subcapsular rupture of the spleen have been reported in cases of typhoid, and in nearly all the cases of traumatic rupture reported there has been, as was the case here, "localized tenderness and rigidity."