FIVE CASES OF TUBERCULOSIS OF THE SYMPHYSIS PUBIS

BY

EILER GREGER

Tuberculosis of the pelvis is by no means frequent and its localisation to the symphysis pubis seems to be quite rare. As this condition is of practical interest and there is little reference to it even in the larger and more recent text-books e.g. Kirschner & Nordman's large and exhaustive work on surgery, I have thought fit to describe the cases which have been treated at the Coast Hospital during recent years.

It is true, that tuberculosis with this localisation has been known for a long time, but in Norsk Magasin for Lægevidenskab reference to it can not be found earlier than 1855 when the following account appeared: "A case of necrosis of the bony pelvis with dislocation of the hip and calculus formation around a bone sequestrum extruding into the bladder. Operation with recovery". From the surgical Department of the State Hospital (Christen Heiberg), reported by Dr. Thilesen. This was a young man who for some years had suffered from disease of the hip with sinuses and separation of sequestra. In 1853 a sequestrum became impacted at the root of the scrotum, causing great difficulty with micturition. Some months before his admission to hospital he developed leakage of urine from a fistula in the right groin. On admission, besides the old standing hip disease there was a fistula in the right groin leading to the os pubis and a solid body in the urethra at the root of the penis. Professor Heiberg operated under chloroform anaesthesia on 5.3.1855: "Sectio prostatica bilateralis with Dupuytren's double litho-

tomy". A calculus the size of a hen's egg was removed with difficulty and was found to have been deposited around a bone sequestrum. Three or four weeks after the operation the wound had healed. Several sequestra were removed from the inguinal fistula which then closed and the patient returned home to get married.

In Scandinavian literature the condition has since been described by *Ole Chievitz* in a special publication dedicated to Prof. Thorkild Rovsing, 26.4.22. Five cases are described; they were diagnosed by radiography. All the cases had been symptom-free until the appearance of gravitation abscesses. The treatment was operative as light treatment did not lead to any result.

In German literature a description of the condition is found in 1872, according to Joachimovitz' publication of 1929, and Ernst Hennies (Greifswald) in 1888 reported three cases which were operated upon with good results. The diagnosis was made after the appearance of abscesses.

In 1890, Chauvel treated a 23 year old man by operation, with successful result.

In 1902 Herz described two cases, both operated upon; one patient died, as permission to operate was not obtained until his general condition had become very poor.

Difficulty in walking was emphasised as an early symptom.

Krause reported in 1902 that he had observed two cases of tuberculosis of the symphysis pubis with abnormal mobility between the pelvic bones.

In later years similar cases have been described by the following authors:—Tillman, Woloch, Mario, Büggner. The last-mentioned was of opinion that adult women were particularly liable to the disease while children were less disposed and this was accounted for by the development of the symphyseal cartilage. Men should be less liable than women for similar reasons. Trauma was advanced as a causative factor as is so often the case in tuberculosis. The primary seat of the disease might be either in the bony parts or in the cartilage. Operative treatment was recommended.

In 1922 Chauveau was able to describe 6 cases of tuberculosis

of the symphysis in children from 5 to 16 years of age. The diagnosis was made by radiography, after the appearance of abscesses or fistulae. Good results were obtained by operative treatment.

The condition has also been described by Rendu, Wertheimer, Reich and Jackson; the last-mentioned had a patient, a girl of 11 years, with an abscess of the thigh. The diagnosis was established by radiography. Aspiration and light treatment had a good effect.

In U.S.A. Swyngheadauw and Druon reported a similar case in 1923 and at the same time gave a statistical account of 33 collected cases. Of these 19 were cured, 4 did not improve and in the remainder the result was unknown.

In 1924 professor Clermont (U.S.A.) operated on a 28 years old woman for this disease and removed the right half of the symphysis with good result.

In 1930 Bean (U.S.A.) described a case which had gone unrecognised for several years and in which the diagnosis was made by means of radiography. The patient had also been x-rayed previously and on more careful re-examination of the films it was found that definite changes had been present for several years. The patient was operated on under the impression that the condition was osteitis fibrosa and a bone craft was inserted to support the pelvis. The pathological diagnosis was, however, tuberculosis. There was no reaction after operation and the final result was good.

Later there have been occasional cases reported but I shall mention only Joachimowitz who has collected all the known cases in a paper on the differential diagnosis of tuberculosis of the pubic bones (1929)—a total of 111 cases, 7 of which were his own patients.

During the period of my appointment at the Stavern Coast Hospital three patients have been treated for this disease and previously two have been treated. I have received permission to describe the two latter cases.

The three first-mentioned patients also had tuberculosis of other systems but their lesions of the symphysis were well loca-

lised and as they displayed great similarity of symptoms and involved similar difficulties in diagnosis I consider that they should be described together. It is true that I cannot quote a large number of cases, but as they are instructive and were comparatively thouroughly investigated I am of opinion that they illustrate the condition well.

The clinical course of the disease in the five patients is given in the following extracts from the case-notes:

Patient No. 1. Borghild S.

A 21 years old girl, admitted to "C-H" 28.4.30 for tuberculosis of the left hand and T.B. knee. Pirquet +, Wassermann reaction ÷. Pleurisy and tuberculous hand 1929. Autumn 1929, *pain in right hip* on walking, also sometimes at night. The pain disappeared after rest in bed.

28.4.30 on examination: Pleurisy and tuberculosis in hand, improving hip joints clear; sedimentation rate 24 mm/1 hour. Hips N. A. D. X-ray: Symphysis pubis rather indistinct. July 1930: Swelling above symphysis pubis—size of pigeon's egg, situated between the rectus abdominis muscles reaching the posterior border of symphysis. Fluctuant. With rest in bed the swelling rapidly disappeared but reappeared when the patient got up. *Gait: limping with right leg,* trunk held flexed backwards and to the left, Trendelenburg's sign +.

1.8.30. Swelling explored. Pus +: Inoculated into guinea pig: T.B. +. *X-ray:* Outlines still indistinct.

6.10.30. X-ray: Definite change in symphysis pubis: Defect of right side equal in size to a walnut with "mouse-eaten" border. No periosteal thickening. Sequestrum the size of an almond with finely dentate, rarefied border. The previous X-ray films were again examined and the development of the changes could now be traced. See Fig. 1 a, 1 c. Hip joints clear. Still no pain on direct pressure or on compression of iliac crests or trochantera. Rest, insolation and a plaster bandage round the pelvis were followed by subsidence of the lesion, clinically and radiologically. Sedimentation rate constantly 6 mm/1 hour. No recurrence of absess. The difference in the level of the right and left os. pub. gradually decreased.

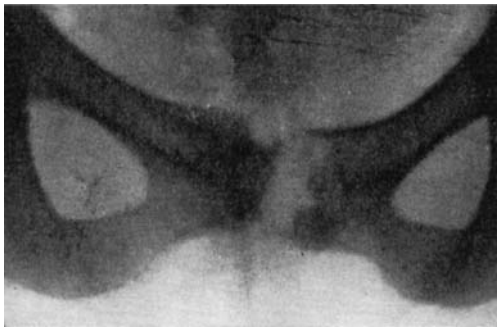

Fig. 1 a.

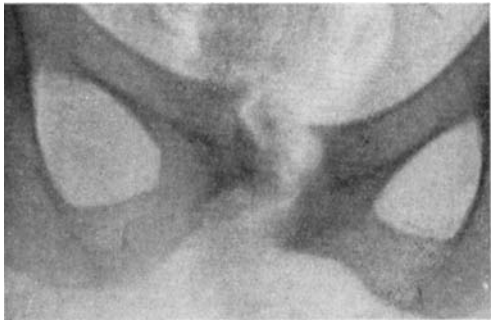

Fig. 1 c.

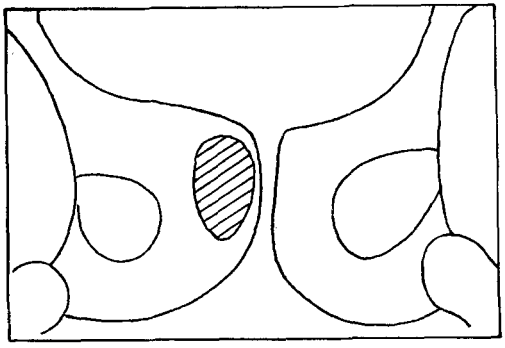

Fig. 2.
From a X-ray photography of case no. 2. The destructed part is scratched.

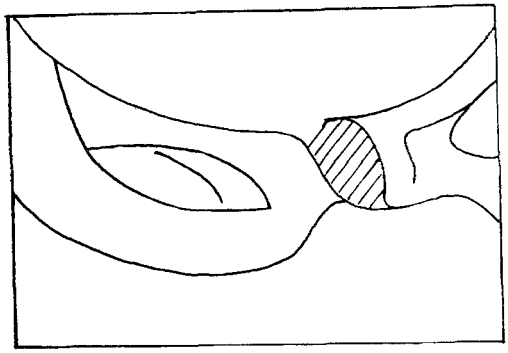

Fig. 3.
From a X-ray photography of case no. 3. The destructed part is scratched.

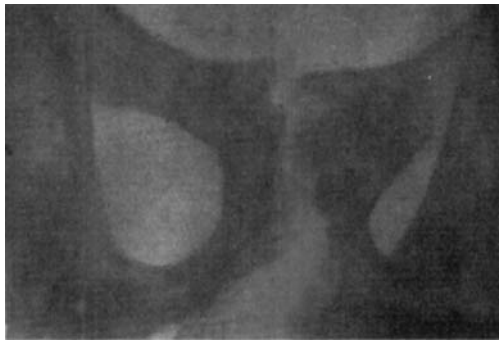

Fig. 4 a.

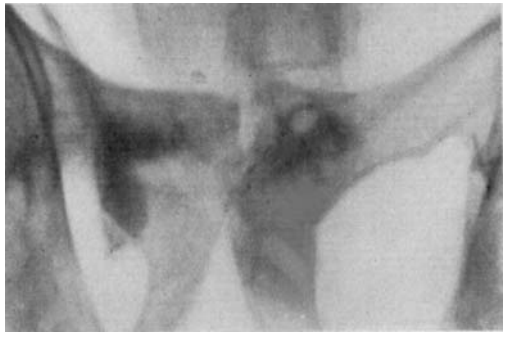

Fig. 4 c.

The abscess was aspirated only once, with injection of iodoform glycerin.

November 1932. Symptom-free but still slight difference in level of horizontal rami of os. pub.

Patient No. 2. Odd A. D-O.

7 years old boy. Patient at "C-H" 22.8.19 to 15.2.21. Pirquet +. Father: tuberculosis of tongue, operated on while the patient was in "C-H" Family and patient otherwise well until the boy received a kick on the right hip at foot-ball, spring 1919. Some time later he began to limp with his right leg. Maximal flexion and pronation of right leg caused pain in region of symphysis. *X-ray:* Rarefaction of right hip region. No atrophy of thigh. Pirquet + (at Ullevål Hospital). On admission abduction and flexion in the right hip were found to be limited. He was kept in bed for several months and became symptom-free. The patient was been allowed out of bed, but soon a swelling appeared on the medial side of the right thigh and a new X-ray film showed *rarefaction of right hip with focal areas of rarefaction in region of symphysis* (16.1.20) Fig. 2. *Palpation of symphysis: No tenderness.* Treated by rest in bed and traction. *31.1.20.* Abscess above symphysis aspirated with injection of iodoform-glycerin—repeated 6.3.20.

26.5.20. Pain in right hip and adductor region. No abscess found. Do. 5.7.20. His general condition was very bad.

4.8.20. X-ray showed repair of symphysis lesion.

25.9.20. Pain in the thigh. X-ray showed two foci in the symphysis with extension into the hip joint. Pronounced rarefaction. Abscess palpable per rectum. Aspiration of abscess with injection of iodoform-glycerin—repeated several times during the remainder of the year.

1921. New abscess in right iliac fossa, close to os pubis and, in February, new adductor abscess. All abscesses aspirated but several spontanous sinuses appeared, with profuse discharge. General condition rapidly deteriorated and patient was removed by relatives. Multiple tuberculosis. Died in March 1921 at home. No autopsy.

Patient No. 3. Irene S.

Aged 49 years. Admitted to "C-H" 12.8.28, discharged much improved 14.3.31. Pirquet: +. Wassermann reaction ÷. Previously healthy, one child. After an injury in 1925 (she fell downstairs) the patient had a pain in right hip. Was kept in bed for 6 weeks. In the following year, pain in region of symphysis on bending forward and nut-sized abscess in the right labium majus. This was incised and the persistence of discharge from the resultant fistula led to the patient's admission to hospital. Excision of inflammatory tissue (histologically granulation tissue). Continued discharge, second admission to hospital and re-operation. X-ray: advanced destruction of symphysis region. Altogether so much tissue was removed as to leave a cavity the size of an egg. Later,—adductor abscess. Re-examination of wound—histological examination of tissue—T.B. + (3.2.28). The fistula persisted until 1930 when it closed completely as did also a sinus from the hip joint which had appeared in the autumn 1928. The lesions in the symphysis and right hip improved greatly with treatment by plaster cast, and the X-ray (see reproduction Fig. 3) shows this. There is some dislocation of the pubic bones with difference in level of the horizontal rami. Pt. discharged much improved, with leather support.

Patient No. 4. Martin H.

Aged 36 years. Admitted to "C-H" 1925—died there 20.6.31. Healthy family. 25 years previously, graviation abscess at back of left thigh —. No other symptoms. The following year, tuberculosis of wrist, with fistula lasting 5 years. 17 years ago injury to lower part of back with pains there on stumbling. 13 years ago gravitation abscess at back of left thigh. The following year, constant pain in pelvis and new fistula. Spinal caries diagnosed and jacket applied but pains in pelvis were not relieved. X-ray at "C-H" 1925 showed advanced destruction of symphysis pubis with sequestrum and involvement of ischia. After admission, repeated opening of fistula and sequestrectomy by broad Incision. In 1928 symptoms of a left sided hip disease appeared, and it was treated by traction for a couple of years. Eventual-

ly albuminuria from 1926; this increased progressively until the patient died from uraemia in 1931. The numerous tuberculous lesions had then healed with exception of a small focus in the ischium. X-ray pictures Fig. 4 a, 4 c.

Patient No. 5. Trygve N.

Born 1896. Admitted to "C-H" 30.6.29, discharged 21.11.29. Pirquet +. Wassermann reaction —. Healthy family. Previously well. 10 years before pain in right leg and groin noted during athletic exercise. A couple of weeks' massage, swelling in right groin rapidly increasing to size of a fist. High temperature. Incision, Pus +, later bone splinters.—Discharge from fistula for several years. Fistula eventually closed. Spring 1929 abscess in R groin—repeated aspiration with injection of iodoform-glycerin. Spontaneous perforation. On admission to "C-H" there was found, besides the sinus from this abscess, a small sinus leading to symphysis pubis. X-ray showed defect of os pubis with a couple of sequestra. Sequestrectomy and insolation caused rapid healing of fistula so that patient was able to return home after barely 5 months in "C-H".

SUMMARY

From the previously quoted cases of tuberculosis of the symphysis pubis and from the five cases treated at Stavern Coast Hospital, it appears that this disease, though rather uncommon, is nevertheless more frequent than one might believe. In all, 130 cases have been described, thus many more than of septic osteomyelitis in the same region. According to Professor G. Søderlund's report in the special publication dedicated to Prof. P. Haglund (1930) only a tenth of this number of similar cases were known at that time. As a rule this lesion begins insidiously, in patients with tuberculosis localised elsewhere. It attacks patients of both sexes and all ages, from 3 years to 70 years. Injury has been invoked as a causative factor, usually indirect violence to the pelvis, as in three of our patients, and not direct injury to the symphysis.

Pregnancy does not seem to be a predisposing factor as opposed to septic ostemyelitis (Søderlund).

The earliest symptom is a feeling of tiredness in the legs, and perhaps walking with a limp, as often proved by Sundt without any demonstrable changes in the legs. Pain in one hip, without other objective changes than slightly limited abduction, may be an early symptom but the most common cause of the patient's seeking advice has been an abscess, either in the neighbourhood of the symphysis or at the medial side of the thigh or in the anal region.

Pain in the symphysis region is frequently completely absent; neither spontaneous pain, nor pain on pressure over symphysis, or on compression of the iliac crests being complained of. But occasionally there is pain on compression of the iliac crests.

A later symptom is the appearance of fistulae, near to or distant from the site of the disease.

Xray examination will reveal the great majority of cases, and by a series of films we may follow the destruction of bony parts, the formation of sequestra and the development of abscesses. It is but rarely that Xray films of the stage of rarefaction have been obtained, or those showing no more than the shadow of an abscess in the os pubis. Our Xray reproductions are not as good as might be wished but cases Nos 1 and 2 showed in their first glass plates changes so slight that it was not possible to decide whether they were pathological.

Sequestra will usually be seen in the form of "mouse-eaten" bone fragments, as described by Å. Åkerlund in other tuberculous lesions.

Later, as the disease progresses, there appears a difference in level of the two horizontal rami of the ossae pubis, with an oblique position of the pelvis.

In order to obtain realizable X-ray pictures we must take care to avoid the possible sources of error which may lead us astray. The patient's bowel and bladder must be empty and the symphysis must be projected as clearly as possible; a prone position may be required for this. It will also be advantageous to secure films from healthy subjects of the same age and sex

for comparison, and to have pictures of both hips on the same film.

In patients with this localisation of tuberculosis the general condition is but little affected for a long time; they often have no rise of temperature and are often without symptoms from the neighbouring pelvic organs.

Help in diagnosis may be obtained from the Pirquet test, the Wassermann reaction, the blood sedimentation rate, inoculation of pus into a guinea pig and, in some cases, histological examination of excised tissue, and examination of the leucocytic blood picture by the Arneth-Schilling method.

A number of different conditions must be considered in the differential diagnosis of affections of the symphysis pubis. This is particularly the case when abscesses are present. A supra-symphysial abscess may, when very tense, resemble a tumour or may simulate hernia, gumma, gonococcal abscess or chronic septic osteomyelitis. The abscess may gravitate to the adductor or the anal region or, via the obturator canal into Scarpa's triangle. Rupture into the bladder may also occur. Further, according to R. Joachimowitz (1929) a number of even rarer conditions may cause confusion.

In our cases, for example, No 1 resembled for a long time early hip disease, spinal caries and salpingitis. No 2 to some extent resembled spinal caries, No 3 septic osteomyelitis and No 4 spinal caries.

The *prognosis* of the condition is largely dependent upon whether the patient is brought under treatment and on the extent of the accompanying tuberculous lesions elsewhere in the body.

In treatment the first essential is treatment of the general condition: rest in bed, insolation, natural or artificial, Xray therapy and diet, possibly Gerson diet.

If abscesses be accessible they should be aspirated and necrosis with separation of sequestra should be treated by operation.

Patient No 1 appeared to recover without this operative interference.

Support may be given to the pelvis by a plaster cast, or, when there is a considerable hiatus between the ossae pubis, good results may be achieved by the insertion of a bone graft, as in Bean's case. A female patient would probably have little chance of successful parturition if the symphysis were fixed in this way.

My thanks are due to my chief, medical superintendent Sundt, for helpful advice and for permission to use the hospital's material.

ZUSAMMENFASSUNG

Aus den früher angeführten Fällen von Tuberkulose der Symphysis pubis und aus den fünf am Küsthospital zu Stavern behandelten Fällen wird ersichtlich, dass dieses Leiden, obwohl ziemlich ungewöhnlich, nichtsdestoweniger häufiger vorkommt, als man glauben möchte. Im ganzen sind 130 Fälle beschrieben worden, also bedeutend mehr als von der septischen Osteomyelitis in derselben Region. Nach dem Bericht von Professor G. Söderlund in der Festschrift für Prof. P. Haglund (1930) war damals von ähnlichen Fällen nur ein Zehntel dieser Anzahl bekannt. In der Regel hat diese Läsion einen heimtückischen Beginn, bei Patienten nämlich mit einer Tuberkulose, die an anderer Stelle lokalisiert ist. Sie befällt Patienten beiderlei Geschlechts und aller Altersstufen, von 3 Jahren bis zu 70 Jahren. Verletzung ist als ein ursächlicher Faktor genannt worden, gewöhnlich in der Form einer indirekten gewaltsamen Beschädigung des Beckens wie bei dreien unserer Patienten, also nicht als direkte Verletzung der Symphyse.

Schwangerschaft scheint, im Gegensatz zur septischen Osteomyelitis, kein prädisponierender Faktor zu sein (Söderlund).

Das früheste Symptom ist ein Gefühl von Müdigkeit in den Beinen und vielleicht ein etwas hinkender Gang, wie ihn Sundt oft gefunden hat, ohne nachweisbare Veränderungen in den Beinen. Schmerzen in der einen Hüfte, ohne andere objektive Veränderungen als eine unbedeutend eingeschränkte Abduktion, können ein frühes Symptom sein, doch war der häufigste Grund, aus dem die Patienten den Rat des Arztes suchten, ein Abszess,

entweder in der Nachbarschaft der Symphyse oder an der medialen Seite des Oberschenkels oder in der Analregion.

Schmerzen in der Symphysenregion fehlen häufig ganz; es wird weder über spontane Schmerzen geklagt noch über Schmerzen bei Druck über der Symphyse oder beim Zusammenpressen der beiden Darmbeinkämme. Doch gelegentlich finden sich Schmerzen beim Zusammenpressen der Darmbeinkämme.

Ein späteres Symptom ist das Auftreten von Fisteln in der Nähe oder in grösserem Abstande vom Sitze des Leidens.

Eine röntgenologische Untersuchung kann die überwiegende Mehrzahl der Fälle aufzeigen, und mit Hilfe einer Filmserie können wir die Zerstörung von Knochenpartien, die Sequesterbildung und die Entwicklung von Abszessen verfolgen. Es kommt aber selten vor, dass Röntgenfilme im Stadium der Rarefikation aufgenommen worden sind, oder diese zeigen nicht mehr als den Schatten eines Abszesses im os pubis. Unsere Röntgenreproduktionen sind nicht so gut, wie zu wünschen gewesen wäre, aber die Fälle Nr. 1 und 2 zeigten auf ihren ersten Platten Veränderungen von solcher Geringfügigkeit, dass man nicht entscheiden konnte, ob die pathologisch waren.

Sequester werden gewöhnlich in der Form von »angeknabberten« Knochenfragmenten sichtbar, wie sie von Å. Åkerlund bei anderen tuberkulösen Läsionen beschrieben wurden.

Später, mit dem Fortschreiten des Leidens, erscheint ein Höhenunterschied der beiden horizontalen Rami des os pubis, der durch eine schiefe Lage des Beckens bedingt ist.

Um brauchbare Röntgenbilder zu erhalten, müssen wir die in Frage kommenden Fehlerquellen zu vermeiden achten, die uns irreführen können. Darm und Blase des Patienten müssen entleert sein, und die Symphyse muss so deutlich wie möglich projiziert werden; hierzu ist eine nach vorn geneigte Projektion erforderlich. Es wird auch von Vorteil sein, sich Filme von gesunden Personen gleichen Alters und Geschlechts zum Vergleich zu sichern und Bilder von beiden Hüften auf demselben Film zu haben.

Bei Patienten mit dieser Lokalisation der Tuberkulose ist der Allgemeinzustand lange Zeit hindurch nur wenig angegrif-

fen; sie haben häufig keine Temperatursteigerung und sind oft frei von Symptomen aus den benachbarten Beckenorganen.

Als Hilfsmittel für die Diagnose können von Nutzen sein die Pirquet'sche Reaktion, die Wassermann'sche Reaktion, die Blutsenkungsgeschwindigkeit, die Ueberimpfung von Eiter auf ein Meerschweinchen und in einigen Fällen eine histologische Untersuchung von exzidiertem Gewebe und eine Untersuchung des leukozytären Blutbildes mit der Arneth-Schilling'schen Methode.

Bei der Differentialdiagnose von Affektionen der Symphysis pubis müssen eine Reihe von verschiedenen Umständen in Erwägung gezogen werden. Dies ist besonders dann der Fall, wenn Abszesse vorhanden sind. Ein suprasymphysärer Abszess kann, wenn stark gespannt, einem Tumor gleichen oder kann eine Hernia, eine Gumma, einen gonorrhoischen Abszess oder eine chronische septische Osteomyelitis vortäuschen. Der Abszess kann zum Adduktor durchbrechen oder zur Analregion oder durch den Obturator-Kanal in das Scarpa'sche Dreieck. Ein Durchbruch in die Blase kann auch vorkommen. Ferner können, nach R. Joachimowitz (1929), eine Reihe von noch selteneren Umständen zu Verwechslungen führen.

Von unseren Fällen z. B. ähnelte Nr. 1 lange Zeit hindurch einem frühen Hüftleiden, einer spinalen Caries und einer Salpingitis. Nr. 2 ähnelte bis zu einem gewissen Grade einer spinalen Caries, Nr. 3 einer septischen Osteomyelitis und Nr. 4 einer spinalen Caries.

Die *Prognose* des Zustandes hängt in weiten Masse davon ab, ob der Patient in Behandlung gekommen ist, und von der Ausdehnung der begleitenden tuberkulösen Läsionen an anderen Stellen des Körpers.

Bei der *Behandlung* ist das Wesentlichste eine Behandlung des Allgemeinzustandes: Bettruhe, natürliche und künstliche Sonnenbestrahlung, Röntgentherapie und Diät, möglicherweise Gerson-Diät.

Wenn die Abszesse zugänglich werden, sollen sie aspiriert werden, und eine Nekrose durch Ablösung von Sequestern soll operativ behandelt werden.

Patient Nr. 1 schien sich ohne diesen operativen Eingriff zu erholen.

Das Becken kann durch einen Gipsverband geschützt werden, oder es können auch, wenn ein beträchtlicher Hiatus zwischen den ossa pubis besteht, gute Resultate durch Knochenüberpflanzung erzielt werden wie in dem Bean'schen Falle. Ein weiblicher Patient wird wahrscheinlich nur wenig Aussicht auf eine erfolgreiche Durchfürung einer Geburt haben, wenn die Symphyse in dieser Weise fixiert worden ist.

Meinem Chef, Herrn Chefarzt Sundt, schulde ich Dank für seinen hilfsbereiten Rat und für die Erlaubnis zur Benutzung des Krankenhausmaterials.

RÉSUMÉ

Il ressort des cas antérieurs de tuberculose de la symphyse pubienne relevés et des cinq cas traités au Sanatorium de Stavern, que cette maladie, bien qu'assez rare, est plus frequente qu'on l'avait cru. 130 cas en tout ont été décrits; ce chiffre est beaucoup plus élevé que celui des ostéomyélites septiques constatés dans la même région. D'après le compte rendu que le Professeur C. Söderlund fit dans la publication spéciale dédiée au Professeur P. Haglund (1930), on ne connaissait à l'époque qu'un dixième de ces cas ou de cas similaires. En règle générale, cette lésion débute insidieusement, chez des malades atteints d'une tuberculose localisée ailleurs. Elle attaque les malades des deux sexes, à tout âge, de 3 à 70 ans. On a invoqué comme facteur causal une lésion, ordinairement une lésion indirecte du pelvis, comme chez trois de nos malades et non une lésion directe de la symphyse pubienne.

La grossesse ne semble pas, contrairement à ce qui est le cas de l'ostéomyélite septique, constituer une prédisposition (Söderlund).

Le premier symptôme est une sensation de fatigue dans les jambes et peut-être un léger boîtement, ainsi qu'il l'a souvent été démontré par Sundt, sans modifications apparentes de la jambe. Des douleurs de la hanche, sans autres modifications objectives qu'une abduction limitée insignifiante, peuvent être

aussi parmi les premiers symptômes; toutefois, la raison la plus fréquente pour laquelle le malade vient consulter le médecin était un abcès, situé soit dans le voisinage de la symphyse, soit sur le côté médial de la cuisse, soit dans la région anale.

Les douleurs font souvent défaut dans la région de la symphyse; elles n'existent ni à l'état spontané, ni sous forme de douleurs à la pression sur la symphyse ou à la compression des épines iliaques. Toutefois, on peut observer occasionnellement des douleurs dans ce dernier cas.

Un symptôme tardif est l'apparition d'une fistule dans le voisinage ou à une plus grande distance du siège de la maladie.

L'examen radiologique dévoile la plupart des cas et au moyen d'une série de films, nous avons pu constater la destruction de la partie osseuse, la formation d'une séquestre et l'évolution d'abcès. Il est cependant très rare que des radiographies aient été prises dans le stadium de la raréfaction ou bien celles-ci ne montrent en tout cas rien d'autre que l'ombre d'un abcès dans le pubis. Nos reproductions radiologiques ne sont pas aussi bonnes que nous aurions pu le désirer, mais les cas 1 et 2 montrent, sur la première plaque, des modifications si minimes qu'il n'était pas possible de dire si elles étaient pathologiques ou non.

D'ordinaire la séquestre apparaît comme un fragment d'os »rongé«, ainsi qu'il a été décrit par Å. Åkerlund, dans d'autres lésions tuberculeuses.

Plus tard, lorsque la maladie évolue, il apparaît une différence de hauteur entre les deux branches horizontales du corps du pubis, conditionnée par la position oblique du pelvis.

Afin d'obtenir des radiographies sur lesquelles on puisse s'appuyer avec certitude, il faut autant que possible éliminer toutes les sources d'erreur qui peuvent entrer en ligne de compte. Les intestins et la vessie du malade doivent être vides et la symphyse doit être projetée aussi clairement que possible; afin d'obtenir cette projection, le malade doit être incliné en avant. Il y a également avantage à posséder des plaques de personnes saines, du même âge et du même sexe, à titre de comparaison, ainsi que d'avoir le radiographie des deux hanches sur le même film.

Chez les malades présentant cette localisation de la tuberculose, l'état général ne s'en ressent que très peu, pendant longtemps. Ils n'ont aucune élévation de la température et ne présentent aucun symptôme dans les organes pelviques avoisinants.

Comme moyens auxiliaires susceptibles d'être utiles en ce qui concerne le diagnostic, on peut avoir recours aux réactions Pirquet et Wassermann, à la sédimentation globulaire, l'inoculation du pus aux cobayes et, dans certains cas, à l'examen histologique de tissus excisés, ainsi qu'à l'examen de la formule leucocytaire de sang, d'après la méthode Arneth-Schilling.

Pour établir le diagnostic différentiel des affections de la symphyse pubienne, il faut tenir compte d'une série de circonstances. C'est notamment le cas lorsqu'il y a des abcès. Un abcès supra-symphysaire peut, lorsqu'il est enflé, ressembler à une tumeur ou être confondu avec une hernie, un syphilome, un abcès gonorrhéique ou une ostéomyélite septique chronique. L'abcès peut déboucher à l'adducteur, dans la région anale ou en passant par le canal obturateur dans le triangle de Scarpa. Il peut aussi déboucher dans la vessie. Par ailleurs, d'après R. Joachimowitz (1929) un certain nombre de faits rares peuvent prêter à confusion.

Parmi nos cas, le premier par ex. ressemblait pendant longtemps à une affection précoce de la hanche, à une carie céphalo-rachidienne, puis à une salpingite. Le No. 2 ressemblait, dans une certaine mesure, à une carie céphalo-rachidienne, le No. 3, à une ostéomyélite et le No. 4 à une carie céphalo-rachidienne.

Le prognostic de la maladie dépend fortement du moment auquel le malade est mis en traitement et de l'étendue des lésions tuberculeuses, localisées ailleurs dans l'organisme.

En ce qui concerne le traitement, l'essentiel est de soigner l'état général: repos au lit, insolation, thérapie aux rayons X et régime diététique, si possible régime Gerson.

Si l'on peut atteindre l'abcès, il y a lieu de l'aspirer; les nécroses avec formation de séquestre doivent être traitées opérativement.

Le malade No. 1 semble se guérir sans intervention chirurgicale.

Le pelvis peut être soutenu par un bandage de gypse; l'on peut également, s'il y a un hiatus considérable de l'os pubis, obtenir un bon résultat par l'insertion d'une greffe osseuse, comme dans le cas de Bean. Lorsque la symphyse pubienne a été fixée de cette manière, il est peu vraisemblable qu'une femme puisse accoucher normalement.

Je tiens à exprimer à mon chef, le Médecin-Chef Sundt, mes plus vifs remerciements pour les bons conseils qu'il a toujours été prêt à me donner, ainsi que pour son autorisation à faire usage des observations de l'hôpital.

LITERATURE

Bean, H. C.: "Tuberculosis of the Symphysis Pubis". Journal of Bone and Joint Surgery, vol. 12, no. 2, 1930 pp. 345—352.

Chauvel: "Osteite Tuberculeuse du Pubis". Bull. et Mem. Soc. de Chir. de Paris, 16, 430, 1890.

Chaveau, M.: "Contribution à l'étude des Osteite tuberculeuses juxta coxales d'après 20 observations recu à l'Hôpital. Maritime de Berck". Paris, 1922.

Chievitz, O.: "Ostitis tuberculosa symphysis pubis". Festskrift for Professor Rovsing, 1922, p. 77.

Clairmont: "Tuberculous Osteitis of symphysis Pubis etc.". Brit. Journ. Surg. 12, 606, 1924—1925.

Hennies, Ernst: "Zur Kenntnis der Fälle von Caries der Symphyse auf Grund klinischer Beobachtung". (Inaugural Dissertation). Greifswald 1888.

Joachimowitz: "Über die Differentialdiagnose der Schambeinstuberculose beim Weibe". D. Zeitschrift f. Chirurgie, 1929, p. 219.

Kirschner & Nordmann: Gesamte Chirurgie Bd. 2, Teil 2, 1930.

Reich, L.: "Ein Fall von Karies der Symphyse als Osteosacrom diagnostiziert". Fortschritt a. d. Gebd. Röntgenstrahlen 1924, Bd. 31, Heft 5/6.

Söderlund, Gustaf: "Über die septische Osteomyelitis in Os Pubis". Acta Chir. Scand. Festschrift professor P. Haglund, 1930.

Thilesen: "Tilfælde av necrose i bekkenbenene, stendannelse om et i blæren indtrængt necrotisert benstykke etc. Norsk Magasin for Lægevidenskapen 1855.