COMPLETE HYSTERECTOMY

FOR MY SECOND CASE OF PREGNANCY COMPLICATED BY FIBROID TUMOR, WITHIN TEN MONTHS.

BY

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(With one illustration.)

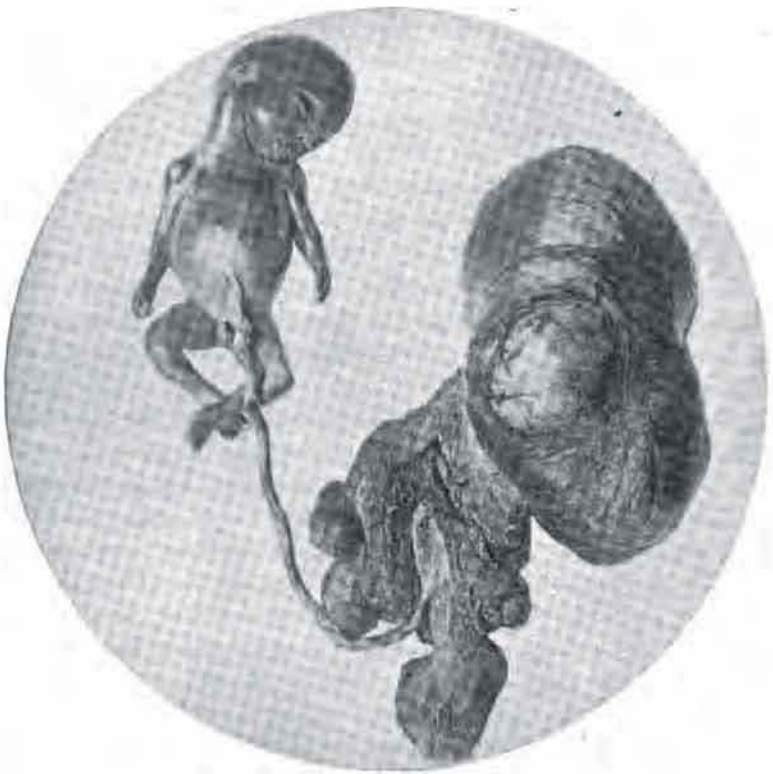
In the September, 1891, number of The American Journal of Obstetrics I reported, among other cases, one of a large thirty-five-pound myoma growing by a pedicle from the broad ligament, accompanied by a five months' pregnant uterus. In that case a supravaginal hysterectomy was performed. The tumor was removed with the pregnant uterus, and the patient made a good recovery.

On the 4th of March, 1892, a lady consulted me in my office regarding a tumor in the lower abdomen. She was 40 years of age; had been married eleven months, but had never been pregnant. Her complexion was somewhat sallow, general health good, family history good, no dysuria. Menstruation ceased on the 12th of December and had not reappeared up to the time I saw her—namely, March 4th. It had thus been suppressed for nearly three months. The menstruation previous to this had been copious, accompanied by clots, lasting from four to five days. There had been no intermenstrual discharge.

She first noticed a lump in the side in November, 1891, just one month previous to the last menstruation. She only suffered from pain if she stooped. The lump was increasing in size. The tumor, when first noticed, was about the size of a hen's egg, and it could be moved from left to right without causing pain. It never caused any pain until recently, and she suffered from it a little now—an uneasiness if she lay on the left side. When I saw her the tumor was about the size of a fetal head. Owing to the probable existence of pregnancy, no sound was used, and it was difficult without an anesthetic to make out the exact position of the fundus uteri. My diagnosis, as entered at the time,

lay between multilocular ovarian tumor and fibroid tumor, either of them probably coexisting with pregnancy.

The patient was admitted into the hospital under my care for further examination. She suffered from a very severe cough, and, as it continued to trouble her, I advised her to return home for a time and to come back when it was better. She did so. About two weeks after, she returned. The tumor had then in-



creased rapidly in size, and I concluded laparatomy was desirable. Everything was made ready, but a telegram arrived stating that the patient's brother was very seriously ill, and she concluded to return home at once.

A deep sulcus could now be felt between the two masses, one mass being toward the right side of the pelvis, the other mass pressed up against the lower edge of the ribs on the left side. This pressure upward against the ribs caused her great uneasiness, and if you will take a glance at the photograph of

the tumor you will readily understand how inconvenient such a lump would be, pressing against the stomach, the diaphragm, and the heart. It seemed strange that twice operative interference should be postponed, and that after the death and burial of her relative she should return once more.

I operated on the 20th of April. On opening the abdomen I found a large, solid tumor pressed up under the ribs on the left side, and another tumor, covered with nodules, in the pelvis and toward the right side of the lower abdomen. This latter looked like a pregnant uterus. I now examined through the vagina, and, with the hand in the abdomen, concluded that it was a case of fibroid tumor growing from the left side of the fundus of a four and one-half months' pregnant uterus. I put in the corkscrew and drew out the tumor and the uterus, tied up the broad ligaments on each side, put on the rope clamp, and thus removed the tumor. I then had Eastman's staff passed into the vagina, and cut down on this from above through the cul-de-sac of Douglas. I then passed one finger into the vagina—the index finger of my left hand—and began to suture and cut the interabdomino-vaginal tissue surrounding the cervix. In this way I removed the entire uterus. I then caught the ligatures together by a pair of forceps passed up from the vagina, and drew down with them a twisted rope of iodoform gauze. The iodoform gauze and sutures were thus lying in the vagina, and the serous surfaces of the peritoneum surrounding the opening were approximated by this funnelling of the hole where the cervix had been.

The patient left the table with a pulse of 82 and a temperature of 98⅘°, while her respirations were but 20. The cough was somewhat troublesome and seemed to return. The discharge by the vagina was quite free and serous. Unless this discharge is free, my experience now tells me that the drainage is very imperfect and the danger to the patient is great. The cases I have had recover after this total extirpation of the uterus have all had a very free serous discharge through the vagina. My friend Dr. Eastman, the originator of this method in America, tells me that he has been thoroughly impressed with the same fact, and now has given up vaginal drainage, using instead drainage through the abdomen after complete approximation of the serous surfaces covering the interabdomino-vaginal opening. If the pouch of the peritoneum in the cul-de-sac of Douglas is congenitally pro-

longed further downward than usual, the opening left after removal of the cervix is not in the most dependent place and therefore will not allow of perfect drainage. A residuum in these cases will remain in the pouch of Douglas. It is well known that if the serous stream is kept flowing away from the system and away from the peritoneum, the danger to the patient is very much diminished. If, however, this drainage is not carried on, but the stream is in the opposite direction and absorption takes place rapidly through the lymph stomata of the peritoneum, the danger to the patient is very much increased.

At a post-mortem examination of one of my patients, who died after complete extirpation, a small collection of pus was found in this very cul-de-sac of Douglas. The opening from the abdomen to the vagina had closed, and drainage was not perfect from the first. The iodoform gauze in the vagina was hardly moistened by discharge. After this operation I found, as in the other cases in which I have performed total extirpation, that the distention occurring on the second and third days was readily overcome by sulphate of magnesia and calomel and a couple of cathartic pills. On the third day the breasts became hard and slightly tender. The patient's temperature never went above 100½°, and her pulse reached 112 on the eighth day. On the fifth day a slight bloody discharge was found on the pads over the external genitals. On the ninth day the discharge had ceased coming through the gauze drain in the vagina. On the tenth day the iodoform gauze was drawn out of the vagina. On the twentieth day all ligatures but one were found to be loose and were removed from the vagina. On the twenty-ninth day the patient's temperature was normal, pulse 88, respirations 20, appetite good, and she was feeling very well. The wound entirely healed; all stitches had been removed, with the exception of one stitch that still remained in the vagina, not as yet loose enough to come away. As I have on one occasion cut such stitches away, leaving the knot, I will never do so again. As long as the stitch is left so that it can be pulled by the nurse every day or two, it will readily work its way out. If the end is cut short this cannot be so easily accomplished.

As I was going away from home and the patient was feeling so well, I gave her permission to sit up. She got out of bed the following day and remained well until the 23d of May. On this day she felt well until noon, when she complained of sudden

severe epigastric pain. As I had left town, she was attended by one of my confrères. This pain lasted for twelve hours. It was relieved by opiates, turpentine stupes, and an enema. It became worse again, however, on the following day, and the patient vomited greenish fluid three different times. Enemata were given, but were not effectual. Though the temperature had remained normal, and even subnormal, the pulse now reached 120. On the 25th she felt somewhat easier, but after a time again became worse. She vomited in all sixteen times. Sulphate of magnesia was given, and enemata were repeated several times, but with no effect. On the 26th the vomiting continued. Hiccough occurred several times in the forenoon, temperature at 97⅘°, pulse reached 116. She slept all the afternoon. Toward night the pulse reached 120; next morning—that is, the 27th—it reached 129, respirations 16. In a stupor from 3 to 5 A.M. Vomiting did not occur frequently; enemata were still ineffectual. On the 28th pulse reached 132; the vomiting continued. She died at 6:45 on the 29th.

A diagnosis of intestinal obstruction had, of course, been made. In my absence the friends refused to allow any operative interference. After death it was found that a small portion of intestine had become adherent to the abdominal incision below the edge of the omentum, and that another loop had slipped through above this adhesion between the bowel behind and the abdominal wall in front and had thus become obstructed. A ready relief might have been obtained by operation, had the friends seen fit to accept the only remedy that held out any hope.

When I arrived home I was very much surprised to find that the patient was dead. I never left any patient in a better condition four weeks after operation than I left her in. She was bright and cheerful, and hopeful for the future. The unpleasant surprise spoiled half the pleasure of my holiday.

Much of my concern was for the new operation, or, perhaps more properly speaking, the resurrected operation. Up to this time my cases, though not numerous, had all recovered after total extirpation of the uterus by this method, and I felt that some of the critics would say that this fatal result was in some way due to the method of operation employed. In my own mind, however, though the case ended fatally from intestinal obstruction thirty-nine days after the operation, the method proved itself a

reliable one in all particulars. I never saw an easier or a better convalescence following hysterectomy.

I publish this case because I believe that it is well to publish such cases. They can teach us a great deal. When I read some of the papers consisting of the histories of a large number of cases without a death, I often fail to pick out one single point that is of value; but in nearly every case in which some unusual complication has occurred the idea or suggestion fixes itself in the mind of the reader and is stowed away for future use. I believe that faithful records of unsuccessful cases would teach us more than faithful records of successful cases. But how few of the unsuccessful cases are reported!

As to the operation in this case, one may say, as is so often said, that it was entirely successful. Probably so, as far as the operator was concerned; but what about the poor patient? I consider that an operation is only successful when it either averts impending death, completely relieves certain symptoms, or restores the patient to health. I frequently see, after the record of cases, the fact mentioned—and it seems to be the especial care of the operator to have it mentioned—that the operation was not in any way responsible for the death of the patient. But surely if the operation did no good, and did not save the patient's life, it did not fulfil the expectations of the patient and the patient's friends.