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REPORT OF THREE CASES OF UTERINE FIBROIDS COMPLICATED BY PREGNANCY.[1]

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(With two illustrations.)

PREVIOUS to the advent of abdominal surgery and of aseptic midwifery the management of pregnancy complicating fibroids was most unfortunate. Of two hundred and twenty-eight cases of labor complicated by fibroids collected by Gusserow,[2] more than one-half of the mothers and two-thirds of the children died. The assumption that many of these deaths may have been due to meddlesome interference on part of the obstetrician is contradicted by Süsserot's[3] carefully compiled tables. Among one hundred and forty-seven such cases of labor collected by him, seventy-eight mothers died. Of the sixty-one mothers requiring manual or instrumental aid, thirty-three

[1] Read before the American Association of Obstetricians and Gynecologists, at Richmond, September 22d–24th, 1896.

[2] "Cyclopedia of Obstetrics and Gynecology," vol. ix., p. 316.

[3] Ibid., p. 314.

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died. The remaining forty-five deaths were therefore among the eighty-six cases not interfered with. The labors allowed to go to a natural termination were undoubtedly those in which there was the least hindrance to delivery, and yet they ended as fatally as did those subjected to delay, injury, and sepsis.

In the more recent statistics collected by Stavely[1] there are five hundred and ninety-seven cases in which no interference occurred before labor. Of these two hundred and twenty, or thirty-seven per cent, died. This reduction in the mortality is owing to improvement in technique within the last ten years. Among three hundred and seven cases reported as having aborted the death rate was twelve per cent.[2]

It would seem, therefore, that surgical interference, either by myomectomy or by hysterectomy, is followed by more favorable results than are gathered from the statistics above quoted. The number of cases thus treated is, however, as yet insufficient to enable us to formulate any fixed rules for general guidance. Each case must be considered on its own merits and must be managed in accordance with the best interests of the mother and, where possible, also of the child.

Wherever the location of the tumor is not likely to interfere with delivery, or its not too rapid growth will admit of delay until after the viability of the child, a conservative course is clearly indicated. Myomectomy in the interest of the child is justifiable in cases in which dystocia would become a strong probability. At or near term, in event of obstruction to delivery, suprapubic hysterectomy is probably the safest course.

The loss of mothers ought not to exceed ten per cent. The children ought nearly all to be saved.

Dührssen's[3] proposition to deliver the child by vaginal Cesarean section, and then to preserve the uterus or remove it, as the nature of the case might indicate, has yet to be put to the test of experience.

If the fetus must be sacrificed the choice lies between abortion and hysterectomy. It is my belief that the dangers of the latter are less than those of the former ; yet here is the point on which honest opinions will differ. To my mind the accidents attending hysterectomy are more controllable than are the complications of an abortion, in which the hemorrhage may become fatal from inability of the uterine muscle to contract,

[1] Johns Hopkins Bulletin, March, 1894, p. 33. [2] Ibid.

[3] "Der vaginale Kaiserschnitt," Berlin, pp. 27–33.

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or the fibroids may slough and lead to sepsis. In some cases an abortion is impracticable because the cervix is beyond reach.

We have all seen subperitoneal fibroids of the uterus, especially smaller tumors, that have not only not been a hindrance to delivery, but have apparently disappeared after labor. Such can hardly be considered as complications. Of the three cases here reported, the first was a multinodular tumor consisting of large subperitoneal and interstitial nodes. The second was interstitial, extending from the lower uterine segment into the broad ligament. The last was also interstitial, occupying the entire lower uterine segment.

The first case was that of a woman, 41 years old, who was seen by me in October, 1891. She had been married twelve years and had never been pregnant. She had enjoyed good health until about three years ago, when her menstruation became more profuse and of longer duration, sometimes continuing for two weeks. Two years ago she began to feel pain in the right inguinal region, and discovered a lump the size of a hand; this lump continued growing. Ten months ago she noticed a growth on the left side, with pain and gradual enlargement. The pain on the left became the most severe. The suffering had never been excessive. She had been able to be about and do her work until very recently. Her menstruation had ceased on May 1st, 1891, and did not recur. The rapid growth of the tumor and the distress from fulness of the abdomen had finally caused her to seek relief.

The abdomen was enlarged to the size of an eight months' pregnancy. Irregular nodular tumors could be seen through the abdominal wall, reaching to the right hypochondrium on one side and four inches above the umbilicus on the other. The tumor on the right was round, smooth, hard. not fluctuating, not painful; several smaller lumps were attached by pedicles to the larger. The tumor on the left was round, soft, fluctuating. There were no movements, no contractions, no fetal or other sounds. The breasts were not enlarged, the areola not pigmented. The vaginal mucous membrane was bluish; the cervix short, velvety; the tumor projected all about the cervix, more especially on the left, and moved with it. The patient would not for a moment entertain the possibility of a pregnancy complicating her tumor, but thought she was undergoing the change of life. Her distress was such that she insisted on any operation that offered speedy relief. Diagnosis:

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Double ovarian tumor with probable pregnancy, or fibroid with same.

Operation October 17th, 1891. Incision eight inches. Tumor multinodular fibroid of uterus containing five and one-half months' fetus and placenta. Supravaginal amputation. Stump secured by serre-neud. No unusual difficulties, no shock. The tumor consisted of six large interstitial and two subperitoneal nodules, the latter attached to the uterus by broad pedicles. Weight of tumor, exclusive of amniotic fluid, twelve pounds. On the day following the operation the pulse

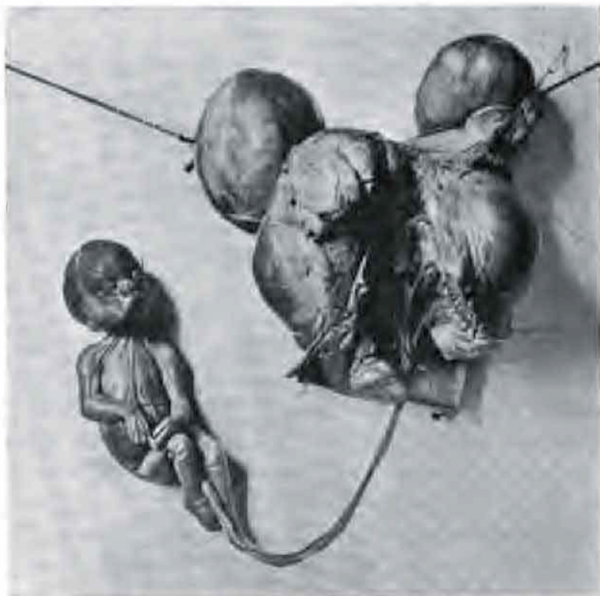

FIG. 1. CASE 1.

was 78, temperature 99°. Urine passed freely. The next day a rapid development of septic symptoms. Death fifty-two hours after operation.

Autopsy.—Pus in the line of incision, over the surface of the intestines and omentum. Half a pint of pus in the pelvic cavity. Upon careful inquiry it was subsequently discovered that the towels in which the intestines had been enveloped while the tumor was being delivered had not been sterilized. The infection came from this source. The fatal result was due to avoidable accident, not to technique.

The afterthought, why would not an abortion have been pre-

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ferable in this case, must be met by the fact that the character of the tumor was not positively made out, and that in case of a pregnancy complicated by ovarian cystoma it was possible to save the child after ovariotomy. Should the tumor prove to be a multinodular fibroid, hysterectomy was deemed more safe than abortion. My disappointment over the deplorable outcome, for personal reasons as well as for the sake of the record, is as keen to-day as at the time of its occurrence.

I first saw the second case, in consultation with Dr. Peskind, in October, 1893, when she was four months pregnant. She was about 34 years of age, had been married twenty years, and had had three children. For two years previous to the present pregnancy she had suffered from profuse menstruation lasting five or six days, attended by painful labor-like pains. The tumor was hard, occupied the smaller half of the pelvis and the right iliac fossa, being drawn up by the pregnant uterus, which occupied the left pelvis and corresponded in size to a four months' pregnancy. It did not seem likely that the tumor would obstruct delivery. Advised non-interference. She was delivered at term, without difficulty, of a healthy child. On examination three months after confinement the tumor could not be found. It seemed to have been involuted with the uterus.

Nine months after childbirth, December 10th, 1894, the patient came to the hospital complaining that for three months she had been having profuse hemorrhages at intervals of two or three weeks, lasting six days, with constant pain in the back, loss of appetite, insomnia. She was quite anemic, emaciated, with a pulse of 112. The tumor had again developed so as to reach an inch above the pubes, and extended out into the base of the right broad ligament. After ten days' use of strychnia and rest the pulse came down to 90, but her appetite and pain remained as before. Hysterectomy advised and accepted.

Operation December 20th, 1894. Trendelenburg position. Incision from umbilicus to symphysis. No complications. Total hysterectomy. Silk ligatures. Stumps turned into broad ligament. Latter closed, shutting off peritoneal cavity completely. Abdominal incision closed. No flushing, no drainage, no shock, no vomiting. Excepting small stitch abscess, her recovery was uneventful. Subsequent symptoms of menopause, and slow recovery from extreme anemia.

The third case, a school teacher, was kindly referred to me

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by Drs. Folkens and Parker. She was 37 years old and had been married twelve years, having had two miscarriages soon after marriage. She had a very healthy appearance, inclined to be stout. Her first knowledge of a tumor was gained after difficult micturition three and a half years ago. For the removal of the tumor a celiotomy had been performed in May, 1893. The tumor, a fibroid of the uterus, was said to have been anchored fast by numerous and dense adhesions to intestines. No attempt was made to remove it. The right ovary was removed. The left could not be found on account of universal adhesions. Recovery was delayed by a mural abscess.

FIG. 2, CASE 3.

The tumor had not increased since the operation until after cessation of the menses four months ago. Now it is rapidly growing larger. There is evening vomiting. Attempts have been recently made to bring on an abortion, but have failed. The cervix is small, pressed tightly against and behind the symphysis. A round, resilient tumor fills the pelvis and rises into the abdomen as far as the umbilicus; most resistant in the posterior cul-de-sac; not nodular, but smoothly rounded. Arterial bruit audible. No movement, no fetal heart sounds. Patient insists on the radical operation; she is unwilling to take any other chances.

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Operation December 23d, 1895. Trendelenburg position. Incision three inches beyond the umbilicus, partly through the old cicatrix. Uterus rounded, non-adherent. Delivered through the incision, and the upper end of the incision closed. Pregnancy in the upper part of the uterus, tumor in the lower. The right appendage is missing. The right upper broad ligament constitutes one huge vein, which is doubly ligated and cut. Considerable recurrent hemorrhage from the dissected bladder flap. A few intestinal adhesions are found low down. Release and close weak points of gut wall. The uterus was amputated according to Baer's method. The peritoneal cavity was completely shut off. No flush or drain. A weak spot in the old cicatrix (ventral hernia) was excised and the abdominal incision closed. No shock. Recovery uneventful.

On opening the anterior wall of the specimen a four months' fetus was found intact in its membranes. The placenta was attached within the left half of the uterus. The tumor occupied the lower segment of the uterus and cervix. It was somewhat edematous, with small spiculæ of lime salts between the capsule and tumor proper.

The location of the tumor and the inaccessibility of the cervix precluded any attempt at abortion with reasonable hope of success. My advice to the patient was to postpone her operation until after viability of the child, which seemed to me to be eminently proper. She, however, was firmly opposed to further delay and the slightly additional risk. She left me the alternative of operating early myself or of abandoning the case to somebody else to do it. Believing, as I do, that a woman has the right to decide for herself in a matter involving danger to life, I consented to do the operation.

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