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"RETROGRADE" ABDOMINAL HYSTERECTOMY WITH AVASCULAR MORCELLATION FOR LARGE FIBROIDS

I. C. RUBIN, M.D., F.A.C.S., NEW YORK, N. Y.

(From the Gynecological Service of Mount Sinai Hospital)

THE removal of a fibromyomatous uterus by morcellation is not a new procedure. It was employed even before the modern method of hysterectomy was fully developed. Morcellation in combination with the standard technic through a relatively small incision has also been practiced, particularly by European gynecologists. The tumor mass was reduced in size until the remnant of the tumor-bearing uterus could be delivered through the abdominal wound after which it was removed in the typical manner.

The advantage which this technic offered the patient, by conserving as much of the abdominal wall as possible, was, however, offset by the considerable amount of blood lost during the process of cutting up the tumor masses. The operation has therefore been abandoned and now

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one generally employs an incision large enough, even though it extends well above the umbilicus, in order to liberate the tumors.

To obviate the blood loss entailed by the preliminary morcellation as previously practiced, at the same time conserving the abdominal wall, I have in the past two years employed in six cases the method presently to be described.

PROCEDURE

The incision is entirely subumbilical. In four of the six cases, although the fibroids reached well up into the epigastric space, the incision was below the umbilicus. The vesicouterine peritoneum is picked up and incised to extend

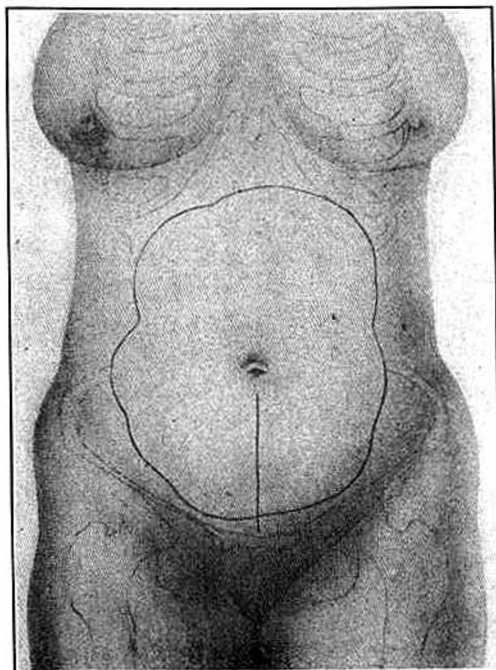

Fig. 1.—Outline of large myomatous uterus reaching the epigastric space in relation to the median suprapubic incision.

to each round ligament which is divided between two ligatures (Fig. 2). If the adnexa are to be removed they are ligated and severed from the infundibulopelvic ligament. If they are to be retained they are clamped off at the uterine attachment and secured by ligatures (Fig. 3). The age of the patient and the condition of the adnexa determine the one or the other step.

The uterine vessels are ligated on both sides, or first on one side, followed by amputation of the cervix. Then the vessels of the other side may be grasped and ligated (Fig. 4). This step is quite the same as that employed by Kelly, Doyen and others, except that the myomatous uterus by the present method is allowed to remain within the abdomen for a few minutes after it is completely severed from its cervical attachment and blood supply. When the tumors are mostly situated

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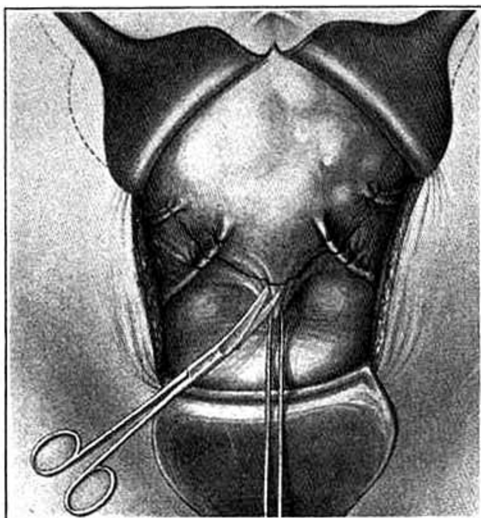

Fig. 2.—Line of incision through vesicouterine peritoneum and across round ligaments. The bulk of the myomatous uterus is in situ, preventing protrusion of intestines.

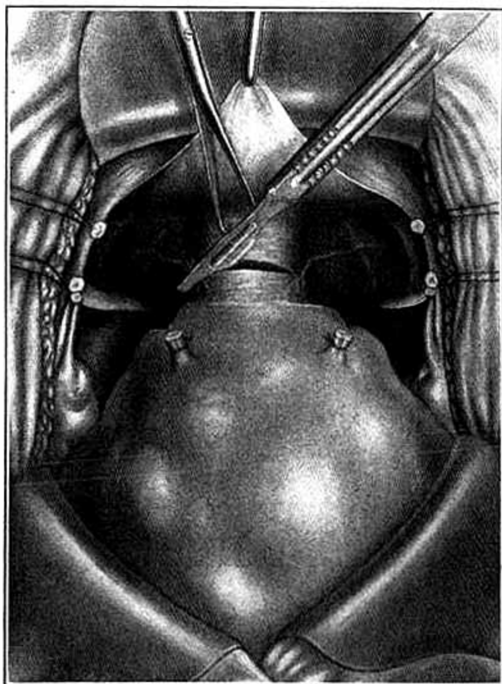

Fig. 3.—The adnexa have been ligated and severed from the uterus; the uterine vessels ligated. Cervix is cut across.

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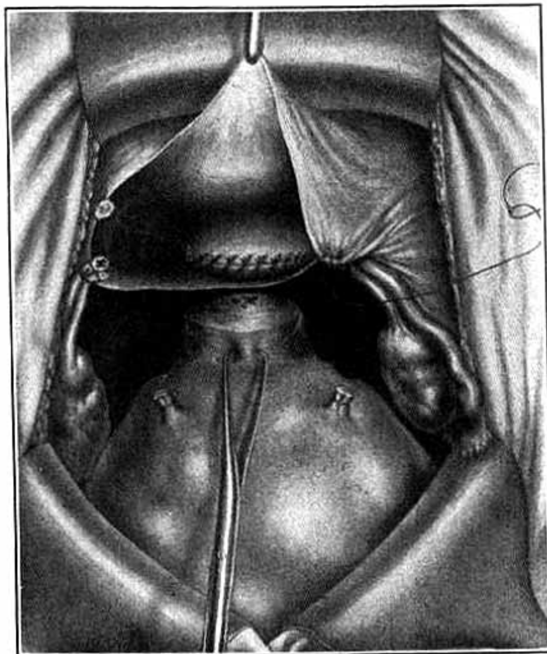

Fig. 4.—The cervix stump sutured and peritonealized together with the adnexal an round ligament stumps.

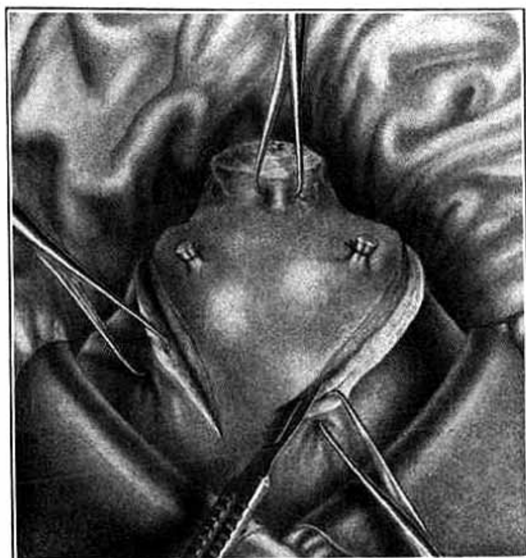

Fig. 5.—The uterus is brought through the wound and a fairly large segment is excised bloodlessly.

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above the round ligament attachments and especially at the fundus, the cervi amputation is exceedingly simple. When the fibroids are intraligamentous and fix by adhesions, care must be taken to get into the proper plane of cleavage, avoidi bladder and ureters, a precaution important in any method of hysterectomy. Th step, however, offers no greater difficulty than when the uterus is actually deliver out of the wound.

After proper disinfection, the cervix stump is sewed over and with it the roun ligaments and adnexal stumps are peritonealized as in the usual technic (Fig. 4. A pad is placed against the pelvic peritoneum. Each side of the abdominal woun is retracted by the heavy curved retractors.

The detached uterus, which has been allowed to remain in the abdomen, is now pulled through the wound by volsellum forceps and is removed piecemeal bloodlessly (Fig. 5). There need be no great hurry in doing the morcellation. The intestines are entirely out of sight. The tumor segments may be excised outside of the abdominal wound in accordance with their number, size, and distribution (Fig.

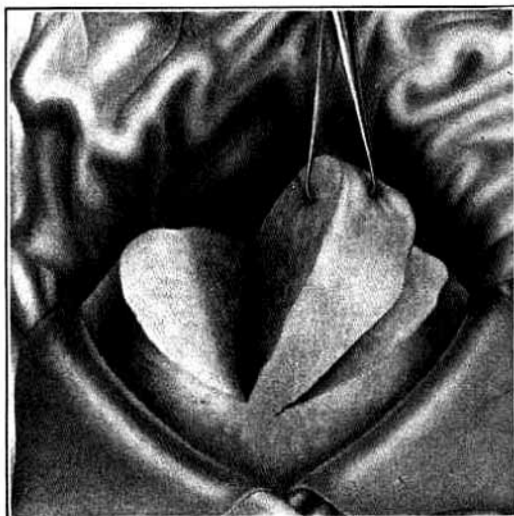

Fig. 6.—The rest of the uterus is removed in segments.

6). This proceeds until the entire uterus has been extirpated. Adhesions can b dealt with properly. The omentum, if long enough, is brought down to underli the abdominal incision. Closure of the abdominal wound is typical.

COMMENT

The feasibility of the method will be grasped at once by the experienced pelvic surgeon. Should greater difficulty be encountered than has been anticipated, or should a malignant degeneration be suspected, it is always possible to extend the incision and then complete the hysterectomy. In one of my cases clamps were applied to the uterine vessels followed by bloodless morcellation, which made it possible to bring the much reduced uterus through the wound, after which it was amputated as in the typical hysterectomy. In two other cases I was able to remove a large pedunculated

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lated fundal fibroid in retrograde fashion by morcellation after ligating the pedicle and dividing it in one case, and clamping followed by division in the other. It was a simple procedure to reduce the size of the fibroid until it could be delivered easily through a relatively small abdominal incision.

The advantages of this procedure may be briefly stated:

1. The smaller incision, all other things being equal, serves to prevent large hernias.

2. As the fibromyomatous uterus is allowed to occupy its natural position during the operation, it acts as a nonirritating pad which prevents the intestines from prolapsing into the wound and from being traumatized.

3. Shock is lessened because of this circumstance and by reason of the fact that the large tumor mass is not at once delivered out of the abdominal wound.

4. Postoperative comfort appears to be comparable to that which follows the average uncomplicated vaginal hysterectomy, two principles of which are utilized in the present technic.

Over the vaginal route, it has several advantages besides the general one of thorough abdominal exploration. It affords the possibility of removing fibroids which reach as high as the xiphoid. The cervix may be retained, leaving intact the vaginal vault. Periuterine adhesions are more readily dealt with and the adnexa may be removed with greater facility, especially when they are adherent.

911 Park Avenue

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