# ABSENCE OF VAGINA—CYST OF VULVO-VAGINAL GLAND —BILATERAL LACERATION OF CERVIX—FIBROID OF UTERUS CAUSING MENORRHAGIA.

CLINICAL LECTURE DELIVERED AT MICHIGAN UNIVERSITY HOSPITAL, JAN. 28, 1892, BY J. N. MARTIN, M. D., PROFESSOR OF OBSTETRICS AND DISEASES OF WOMEN.

Ladies and Gentlemen:—I have given you several laparotomy clinics lately, when I have removed ovaries, tubes, ovarian tumors, intra-ligamentous tumors and the uterus, but to-day we have an altogether different class of cases to discuss and operate upon. I regard these cases, however, of as much, if not of greater value to you as students.

The first patient to be presented, who is now being etherized, has the following history: She is eighteen years of age, was well until fourteen years of age, when she began to have cramping and bearing-down pains in the pelvis. They appeared periodically about once in three or four weeks, remaining three to six days each time. These attacks of pain grew worse and more prolonged from month to month, and were accompanied by loss of appetite, nausea, and sometimes severe vomiting.

At times the patient had severe cramping in limbs, and at other times convulsions during the height of the pain. Large doses of morphia had been given to allay the pain.

Last spring, Dr. Sigler, of Pinckney, Mich., was called to see the case and immediately advised an examination, when he found an obstruction to the menstrual flow; he advised an operation and I was called the middle of June to operate. I found a pale, frail and nervous girl, showing every sign of general debility.

Upon careful rectal and vesical examination no part of the vagina could be found, certainly no distended vagina, but a large mass extending from above the umbilicus down into the pelvis to within a finger length of the anus. The uterus was as large as a uterus five or six months advanced in gestation. The external organs were fairly well developed, and rectum and urethra apparently normal. I operated then as I expect to operate to-day, which operation I will describe as we proceed.

I succeeded then in making a canal through the cellular tissues between the rectum and urethra without injuring either (there was no trace of a vagina). There was not only absence of the vagina, but an imperforate cervical canal at the external os. Fortunately the closure in the cervical canal was shallow.

I succeeded in making a crucial incision and evacuated three pints of a tar-like fluid from the uterus; this continued to ooze for several hours after the operation. The operation was done under full aseptic precautions, without great loss of blood, and the patient recovered nicely from the operation and was, for a time, much improved.

Drainage dilators were used. The operation was done in the country several miles from Pinckney, and I was ably assisted by Dr. Sigler.

Two days later, I started for Europe, and within a few days Dr. Sigler, who was to conduct the after treatment, was taken sick and obliged to go away and the patient passed into other hands, and owing to the many obstacles in the way the canal closed up. It is always difficult to keep it open in such cases.

About two months ago, the mother came to me with the report that the trouble was returning; patient had periodical attacks of pains, etc., and she wished me to go out and operate again. I advised her to bring her daughter to the hospital, where we could more easily conduct the after treatment. She has finally done so, as three weeks ago the pains were very severe again.

Her general condition is much better, but I find upon examination that the canal has closed, apparently the whole length, and an enlargement in the abdomen almost to the umbilicus.

This will serve as a forcible illustration of the necessities of persistent after-treatment, which I will discuss later, as the patient is now ready for the operation.

The bowels have been thoroughly emptied and cleansed, the external organs scrubbed with soap and water and bi-chloride solution, the hair is shaved off. Now we will give the final scrubbing and then proceed with the operation. Our object is to make a canal between the rectum and urethra without wounding the vagina, urethra, or other important organs.

I will first make a shallow incision with a bistoury, between the meatus urinarius and anus, about an inch and a quarter in length, down

to the cellular tissue; then discard cutting instruments in the main, and use my finger and the flat handle of the bistoury. I encounter bands of cicatricial tissue that were not present when I operated before. Some of these I am breaking and some incising. You notice I keep the index finger of my left hand in the rectum and Dr. Lynds is holding the sound in the bladder and against the posterior wall of the same. In my manipulations I endeavor to keep away from the rectal wall and bladder and urethra and am warned by these two guards when I approach too near either.

I have now reached a mass the size of a small hen's egg, which, by bi-manual examination, seems to be below and behind the cervix, and is probably a little sac at the upper part of the vagina. We will work toward the end of the cervix, which I think I can feel. With this bistoury, you see I make a small puncture in the direction of the cervix. The tar-like material, so black and thick, that you now see flowing away, shows we have entered the cavity containing the retained menstrual secretions. We have succeeded in making a canal, but it contains several bands that must be broken or cut. As you see, we are stretching them and carefully incising the stronger ones.

Now that we have a pervious canal of sufficient size for a vaginal dilator, we will give the final douching and introduce this glass vaginal dilator, an inch in diameter; but, in order to afford free drainage, we shall apply three thick strips of iodoform gauze on the sides of the dilator and place loose antiseptic gauze over it and over the parts.

This thick fluid, of which a pint and a half has been evacuated, will continue to flow away for several hours.

The after treatment will consist in keeping the canal open with a vaginal dilator, removing it whenever there is any indication of retention of secretion or decomposition of the same, cleansing with sterilized water and perhaps a weak solution of bi-chloride. We must use warm water, temperature about 100°, and not hot water, as we do not wish to contract the parts, for it would then be more difficult to introduce the dilator. The treatment must be kept up for months. We do not expect, in a case as bad as this, to have as a result a natural vagina, but a canal large enough for the free escape of the menstrual secretions. Persistent after care will do that.

The next patient I shall present for operation is Mrs. C., age 33, from Kendallville, Ind. She complains of a swelling in the left labium major; it dates back two years. It was punctured three times, about a year and a half ago. This diminished the size somewhat, but it soon refilled; at the present time, as you see, the swelling is the size of a large hen's egg. While it has been practically painless in its development, yet now it inconveniences the patient from the pressure. She is now desirous of having it removed.

Upon examination, I find the swelling in the region of the vulvo-vaginal gland; it can be distinctly outlined, and although very tense

there is faint fluctuation. From present indications and from the fact that it has developed so slowly and without inflammatory action, I conclude it is a cyst of the vulvo-vaginal gland. I differentiate from hernia from the fact that it is dull upon percussion, distinctly circumscribed from above, and there is no impulse upon coughing.

There are three different methods of treating these: First; To puncture, evacuate, and inject with iodine. Second; To remove an elliptical outer section of the cyst and curette thoroughly the interior and pack with iodoform gauze. Third; Enucleate the cyst, and,if gland is diseased, remove it. If either of the two latter methods is resorted to, the wound must be kept open till it heals from the bottom.

To remove the gland is usually a bloody operation on account of the plexus of blood vessels in this locality.

The patient is now etherized and ready for operation; the parts have been thoroughly cleansed and rendered aseptic.

I will begin by making an incision over the tumor and will endeavor to enucleate it. As you will observe, I am doing this principally with the fingers and the handle of the bistoury. Now that we have succeeded in separating the tumor from the surrounding structures, except the deep attachment, I cut that off with the scissors. The gland is broken down, so I will dissect it out. As you see, the hemorrhage is quite free; this we are controlling at present by the catch forceps. We will now ligate the principal vessels with cat gut, and stop the general oozing by pressure. Should this external pressure not be sufficient, we will tampon the vagina, and so secure counter pressure. In the after treatment, I regard it as the better method, to get a complete cure, to keep the wound open externally until the interior is well closed, so as to insure against pus pockets or the formation of abscesses; at the same time keeping up moderate pressure so as to keep the lower part of the wound well coapted.

The next case I present is one with bi-lateral laceration of the cervix, Mrs. L., of Milan, Mich., age 33. She gives the following history: She has one child three years old; she was never strong, but since the birth of the child has been much worse, with pains in pelvis, back, etc., and profuse, constant and yellow leucorrhœal discharge. She was examined by Dr. Taylor, of Ypsilanti, about five months ago, when the laceration was discovered. As no other cause could be found for the pain in the back and between the shoulders and the profuse leucorrhœal discharge and dispareunia, an operation was advised, after proper preparatory treatment.

I have examined the case and found the laceration. The acute inflammation and discharge have been reduced by the Doctor's treatment, and I now find indications for no other treatment than the restoration of the cervix. I trust you will recall my remarks made some days ago upon the indications and contra-indications for operations upon the lacerated cervix. When the cervix is lacerated, everted, infiltrated and

kept in an irritated condition by the laceration and consequent eversion, with the symptoms which this patient presents, there is plain indication for operation.

Before operating upon these cases, I assure myself by careful examination that the tubes and ovaries are in a healthy condition. I believe that an operation upon the cervix with Fallopian tubes filled with pus is not only of no benefit, but is often a positive injury to the patient.

Before beginning the operation in this case, you notice we give the vulva and vagina a final scrubbing with soap and water and bichloride, cleanse the cervix and the interior of the uterus with five per cent. solution of carbolic acid, and pass anchor lines through the anterior and posterior lips to hold the cervix in the field of operation.

We vivify in the usual manner, being careful not to encroach upon the cervical canal, and pass the sutures so as to coapt the parts perfectly. We use braided silk for sutures, which has been boiled and kept in absolute alcohol. I need not go further into details, as this operation has been performed and discussed so often before you.

I wished to present two other cases this afternoon, and especially one suffering from menorrhagia and dysmenorrhœa caused by fibroid tumor of uterus, but it is growing dark and we must see them tomorrow morning.

[One month afterward, patient operated upon for absence of vagina has done well and continues to wear a vaginal dilator without pain; temperature has been normal since second day.

In the second case, the cavity from which the vulvo-vaginal gland was removed is closing up gradually.

Third case, ten days after operation, the stitches were removed from the cervix with perfect result.]