FIBROID TUMORS OF THE UTERUS AS A COMPLICATION OF PREGNANCY AND LABOR.

BY

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THE study of the literature of uterine fibroids as a complication of pregnancy and labor is likely to lead to one-sided and misleading results, because the vast majority of publications have as their basis cases in which, for one reason or the other, myomectomy was performed, or comprise reports of cases in which the tumors were the cause of serious symptoms. Cases pursuing a milder course are rarely brought to notice, as in these cases the tumors either escape recognition entirely or are not diagnosed until everything has passed off like any other normal confinement.

I observed during the last two years four cases of pregnancy and labor complicated by fibroid tumors, the report of which, I believe, will form a valuable addition to obstetrical literature. These cases prove the fact that it is good practice to carefully watch these cases, and, if possible, permit the pregnancy to continue undisturbed instead of performing myomectomy upon trivial pretences.

CASE 1.—Mrs. R., a primipara æt. 42, married sixteen years, engaged me for her confinement about three weeks before term. She had passed through pregnancy without much discomfort. Her pelvis was normal. Fetus in left occipito-anterior position. The palpation of the uterus and a vaginal examination demonstrated nothing abnormal.

I was called to see her July 4th, 1892, about 11 A.M., and found that she had been in labor about three hours. The os was fully dilated, the membranes had ruptured, and the head was in the pelvic cavity. Two hours later occurred the spontaneous delivery of a living child. The nurse, who held the uterus while I attended to the delivery of the child, said that she believed there was still another baby in the uterus, and not until then did I find that the uterus contained three fibroid tumors. These tumors were situated in the posterior uterine wall and ranged in size from a lemon to a large apple.

The uterus contracted well after the delivery of the child, and there was no hemorrhage. Thirty minutes later I attempted to express the placenta after Credé, but instead of the placenta coming away there was considerable flooding. I waited half an hour, when I again attempted the delivery of the placenta, with the same result as before. This maneuvre was repeated once or twice, and in addition to the expressive force I added traction upon the cord, but I was unable to deliver the placenta. During these manipulations the woman had lost a considerable amount of blood. I therefore sent for assistance, chloroformed the woman, and delivered the placenta manually. This was not accomplished without difficulty, as the placenta was firmly adherent to the left cornu of the uterus.

The woman passed through a normal puerperium. The tumors rapidly diminished in size and have never caused any further discomfort. I examined the woman eight months post partum, when only a few nodules could be felt.

Case II.—A primipara was referred to me by the United Hebrew Charities and sent for confinement to the Mothers' and Babies' Hospital. She was at full term, the pelvis normal, fetus in left occipito-anterior position, and her general condition good. A firm tumor about the size of a lemon could be felt and seen in the anterior uterine wall. Labor commenced at full term. The os dilated rather slowly, and in demonstrating the case to the class I remarked that the delivery would not take place for several hours. While showing some new instruments to a number of students the nurse came running into the office, stating that the woman had suddenly become pale and that a dark mass was protruding from the vulva. This mass I found to be the unruptured bag of waters, the contents of which appeared to be dark. I immediately ruptured the membranes, and a large quantity of blood-stained water came away. There was also a flow of pure blood from the genitals. The forceps was applied to the head, which was in the outlet, and a living child easily extracted. The placenta and a mass of blood coagula followed at once the delivery of the child. The uterus contracted well and there was no further hemorrhage.

I examined the woman two weeks post partum, and the tumors had so much decreased in size as to be barely perceptible.

Case III.—Mrs. M., a primipara, æt. 30, consulted me when about two months pregnant. She suffered from the usual symptoms of pregnancy and complained of no abnormal discomfort. Very much to my regret I made no vaginal examination at that time; yet I may remark that her family physician, Dr. Louis Waldstein, who kindly referred the case to me, examined the woman a few weeks prior to conception and failed to find anything abnormal in the uterus. A few weeks later she came to my office in the evening, complaining of pain in her limbs and some discomfort when sitting down. She herself suggested as

the probable cause for these symptoms a cold contracted the previous night while sleeping with the window wide open. (During the night there was a sudden temperature decline.) Again I omitted to examine per vaginam, but, thinking that I had to deal with mere rheumatic pain, prescribed the usual remedies.

She intended to leave for the country the following day, and I cautioned her to remain in bed, if not feeling perfectly well, and send for me if necessary. Her husband came to my office the next morning, stating that his wife had been to the theatre the night previous, and coming home they found the elevator had stopped running; she therefore had to climb up six flights of stairs. She had passed a very restless night, and he asked me to see her. I found the patient in bed, complaining of abdominal pain and inability to urinate. She felt faint and her stomach was very irritable. The visible mucous membranes did not look pale. Upon making a vaginal examination I found the vagina distended by an elastic tumor, about the size of a large orange, situated in Douglas' cul-de-sac. The cervix I was unable to make out at that time, but later I found it high up and to the left of the symphysis pubis. It felt like the cervix of pregnancy. To my mind the diagnosis lay between an incarcerated retroverted uterus and a pelvic hematocele. After emptying the bladder I placed the patient in the knee-elbow position, and, introducing two fingers into the vagina, I made firm pressure against the mass, while the other hand was placed upon the abdomen. In a short while I could map out the whole uterus, and found it *not retroverted* and *distinct* from the aforementioned mass. The uterus appeared to be larger than it should be in the third month of gestation. I excluded extrauterine pregnancy upon the ground that for three months she had absolutely no symptoms pointing to this complication, and that the uterus felt to the touch and corresponded in size to the pregnant uterus. I therefore made the diagnosis retrouterine hematocele caused by some unusual bodily exertion, and not due to extrauterine pregnancy. While we must admit that the vast majority of cases of pelvic hematocele are caused by the ruptured pregnant tube, there are still a sufficient number of cases recorded by able observers to make it certain that this accident may be independent of extrauterine pregnancy.

Dr. H. C. Coe, who kindly saw the case with me a few days later, was at first strongly inclined to regard it as one of extrauterine pregnancy, but later he coincided with my views. As to the cause of the hematocele he could also offer no other explanation. I ordered absolute rest, opiates, ice upon the abdomen, and other medication as indicated. The inability to urinate continued for nearly a week, when gradual improvement commenced. Concomitant with this improvement there was a gradual decrease in the vaginal tumor and an enlargement of the uterus. About this time, which was nearly four weeks after the

woman took to her bed, Dr. P. F. Mundé examined the patient and readily found the abdominal tumor, the mass protruding into the vagina, the latter distinct from the uterus. He strongly suspected the case to be one of ruptured extrauterine pregnancy continuing as an abdominal pregnancy. To make the diagnosis absolutely clear it would have been necessary to use a uterine sound, but, as I suspected a living fetus *in utero* and the symptoms were not urgent, we concluded to watch the case carefully and await further developments.

I continued to examine the case regularly, and was gratified to note a gradual disappearance of the vaginal mass and the normal growth of the uterus.

I omitted to remark that at the first examination I felt a resistant mass upon either side of the uterus, which was thought to be the upper limit of hematocele. As the uterus grew larger and could be more distinctly mapped out, these hard masses were recognized as uterine fibroids situated in the lateral walls of the uterus, and later it became evident that the anterior wall also contained a number of fibroids. These tumors participated in the further evolution of the organ, one attaining the size of a large fetal head. Dr. Mundé kindly saw the patient again and confirmed the fact that we had to deal with an intrauterine pregnancy complicated by fibroid tumors and a pelvic hematocele. To sum up the further history of the case briefly, I wish to say that the pelvic hematocele was gradually absorbed and the cervix regained its normal position. The pregnancy continued undisturbed, and a healthy boy was born at full term. Except that the labor was rather slow, finally necessitating forceps delivery, the confinement and puerperium were normal. The tumors gradually declined in size, and, while they have not disappeared entirely, they have never caused any discomfort, and the woman continues to be in perfect health.

In going over this case in my mind after everything had passed off favorably, I have often asked myself the question whether my diagnosis had not been wrong, after all; that I never had to deal with a pelvic hematocele, but that the mass which resembled it consisted of nothing else than a prolapsed fibroid tumor. The arguments which may be made against the latter diagnosis are that the mass did not have the feel of a fibroid tumor, and, as verified by two prominent observers, it appeared to be distinct from the uterus. The tumor was undoubtedly posterior to the uterus, yet repeated careful examinations showed the posterior uterine wall to be free of any tumors. The accident occurred at a time when the uterus was just emerging out of the pelvis, and possibly some adhesions between the new growth and the surrounding parts were broken,

followed by sufficient bleeding to cause the hematocele. This accident appears to be more probable when it is remembered that the tumors at the side of the uterus were freely movable and were of the subserous type. We have, further, the history of an unusual exertion, which has been known as the cause of a pelvic hematocele. I finally observed the mass to shrink and gradually to become absorbed, just as one would expect a pelvic hematocele to behave.

CASE IV.—I attended a lady in her second labor, which proceeded perfectly normally. When I attempted to express the placenta I found two fibroids, about the size of a small lemon, in the posterior uterine wall. There was nothing abnormal during the third period and the puerperium. Again I could notice the gradual disappearance of these tumors, and they had never given rise to any discomfort.

The woman is absolutely ignorant of the fact that her uterus contains these undesirable guests, but I am quite sure that they will never trouble her.

It is not my object to discuss the whole subject of fibroid tumors in pregnancy and labor. This would only be monotonous recapitulation of an old strain to be found in every obstetrical text book and in most papers dealing with this theme, and much of which I believe is decidedly out of tune and harmony with the rational conception of this complication. I intended to devote myself entirely to the study of these four cases and a few general remarks.

In two of these cases there were complications due to the placenta, probably caused by an endometritis, which, according to Waldeyer, Myronoff, and Campe, is usually present in fibromata of the uterus. To my mind an endometritis is the most potent factor in adherent placenta and accidental hemorrhage. While in the first case the placenta was unusually firmly adherent, it became in Case 2 prematurely detached.

Hofmeier thinks the complications in the third period of labor mainly caused by irregular uterine contractions. This seems to be a very plausible theory, but which I could not verify in my cases; in every one of these the uterus contracted quickly and permanently. I may also remark that, in the cases which I found reported, post-partum hemorrhages were not frequently observed, but adherent placentæ were quite numerous.

Slow, painful, and tedious labor one is told to be prepared to meet in uterine fibroids. My cases comprised two old primi-

paræ, in which one expects protracted labor. In both cases tumors of large size were present. Yet in one case labor was rather rapid, and in the second case, after good pains were once established, the expulsive efforts of the uterus were normal. Forceps was only applied in the interest of the child as its heart sounds became slow and irregular.

It is a deplorable fact that obstetrical text books preserve a too great amount of reverence to old dicta, which pass like an endless chain from book to book. Because some writers lost a few confinement cases in which myomata were present, although the tumor was generally *not* the cause of death, this complication is marked as exceedingly serious and we are advised to operate if graver symptoms present themselves. Thus it comes that one man operates on account of pain, and the other because the woman cannot work in the field. Many are the operations reported in which the sole indication was the tumor. But myomectomy during pregnancy is a grave operation, which should not be undertaken except under the most pressing indications.

I omitted to remark that Case 3 suffered from marked distention of the abdomen and consequent pains of varying severity. These symptoms were never serious enough to warrant, to my mind, interruption of pregnancy and myomectomy, but I come across the history of many operations undertaken for far more trivial indications.

It seems to me an absurd statement to say that myomectomy shall also be performed in the interest of the fetus. Certainly in more than one-half of the cases pregnancy is interrupted; and, while I cannot quote any figures, I am sure that a much larger percentage would be saved if pregnancy were allowed to proceed undisturbed.

Under the same heading I class the operations undertaken at such an inopportune time with the view of freeing the woman of the tumor. There are many cases of uterine fibroids which should be operated upon, but rarely is it necessary to resort to the operation while the uterus contains a growing fetus and its nervous and vascular systems are at the highest state of development.

The few cases which I observed prove that even large tumors may cause but slight complications, and I found not a small number of cases reported in which seemingly insurmountable obstacles disappeared during labor and did not interfere with a normal delivery.

The structure of fibromyomata closely resembles that of the uterus. They partake in the evolution and involution of the organ. Growths which may be of alarming size during pregnancy become post partum utterly insignificant and may never cause the woman any discomfort. If they should do so, then it is time enough to resort to their removal.

I consider the operation of myomectomy during pregnancy entirely unjustifiable, and, with but few exceptions, these cases should be let alone until labor has commenced. If it is then found that delivery *per vias naturales* is impossible, then, and only then, has the time arrived to interfere and to perform the sectio Cesarea or Porro operation. Both of these operations give far better results than myomectomy during pregnancy, especially if timely preparations have been made.

Finally, I wish to say that, after a most exhaustive study of the literature pertaining to uterine fibroids, I cannot verify the statement that fibroid tumors are the cause of so many alarming complications. The deaths which are reported are mostly due to *sepsis* and to the *operations*. Women die of sepsis without the presence of fibroid tumors; clean hands are the best prophylactic against that complication. Many of the deaths from the operation were unwarrantable. To perform a myomectomy in or before the third month of gestation, simply because the uterus contains a fibroid tumor, is a class of practice which I group under the heading, "obstetrical tight-rope performances." We frequently see persons walk the tight-rope without breaking their necks, yet it is more prudent to remain upon *terra firma!*

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