CESAREAN SECTION AND PUERPERAL HYSTERECTOMY FOR PREGNANCY COMPLICATING MYOFIBROMA; PORRO'S METHOD.

RECOVERY OF MOTHER AND CHILD.

BY

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Mrs. W. LeB., American, aged 40, was admitted to St. Mary's Hospital August 20th, 1895, with the following history: The mother of nine children, the last of whom was born two years ago after an unusually difficult labor. One year previous to this birth she first noticed a small tumor in the abdomen, which did not increase in size until after childbirth. From this time it grew rapidly, until in the autumn of 1894 it was as large as the pregnant uterus at the sixth month; this rapid growth was accompanied by prolongation of the menstruation and much general disability. Her last menstruation occurred in December, 1894, and with the advent of pregnancy her sufferings were greatly aggravated.

In April, 1895, Dr. A. L. Baker, of Byron, Minn., was called

in and made the diagnosis of pregnancy complicating a large uterine myofibroma. In May, 1895, Drs. A. W. Stinchfield and W. J. Mayo, of Rochester, Minn., saw her in consultation and confirmed the diagnosis. The advisability of interrupting pregnancy was not favorably considered at this time, for reasons given later, and she was advised to wait until near the time of her expected confinement and then enter the hospital for delivery.

During this interval she increased to an alarming degree in size and was confined to the bed almost constantly, requiring morphia at times to relieve her suffering. On admission to the hospital she was subjected to a physical examination which yielded the following results: A slender lady with a normal weight of one hundred pounds; upper portion of body and face emaciated, lower limbs edematous; heart's action 116 and feeble; lungs normal, although the breathing is difficult on account of abdominal distention; micturition frequent, urine contains one-tenth of one per cent of albumin, no casts; nervous system better than the average; abdomen enormously enlarged; the body of the uterus with contained fetus can be felt high up in front to the left; the fetus lies with back anteriorly, vertex downward; fetal heart beat 140; the tumor lies behind and to the right and appears to fully equal the pregnant uterus; the vagina is filled with a tumor the size of the fetal head, evidently in the posterior wall of the cervix; upon examination per rectum this appears to be an hour-glass portion of the abdominal growth rather than a separate tumor; os uteri lies high up in front behind the pubic arch. Examination of the bladder shows it to be carried up nearly to the level of the umbilicus and to the left.

September 6th, 1895: Labor began at 4 P.M. After the usual preparation the patient was removed to the operating room at 5:30 P.M. Chloroform was administered, and an incision made in the cervical tissues covering the vaginal tumor, with a view of enucleating this mass with possible extraction of the child through the vagina, or at least of removing an annoying complication to the operation from above. But after removing a portion of the growth the size of a cocoanut it was found that the result was merely to draw down more of the tumor. The uterine cavity was not opened. The free venous bleeding was checked with a gauze pack and the abdomen opened by a high

incision; an attempt to pass a rubber constrictor over the great mass to its base was quickly abandoned as impracticable. The uterus was incised without much hemorrhage close to the right edge of the placenta, and the membranes were ruptured, allowing the liquor amnii to escape. The child was extracted by the breech, which part was most easily reached. The after-coming head was somewhat tightly gripped by the contracting uterus; the uterine opening was therefore enlarged to permit easy delivery. The cord was doubly clamped and cut, and a living seven-pound boy was handed to an assistant. The placenta was left in the uterus. The abdominal incision was enlarged upward, and each broad ligament doubly clamped and cut below the ovary and tube before the mass could be turned out of the abdomen. The bladder was dissected off in the usual manner and the wire need adjusted so as to include the broad-ligament stumps; and by partly removing the gauze pack from the space from which the tumor had been attacked on its vaginal aspect, the relaxed capsule with the cervix from below was brought well up into the constrictor. The pins were inserted and the tumor with the uterus cut away. The stump was fixed in the lower angle of the wound and the abdomen closed in the usual manner. The operation of an hour was well borne and the patient was put to bed in good condition. The after-history was unimportant. The pedicle, which the vaginal enucleation of the lower part of the tumor rendered of small size, separated in ten days and the mother made an uneventful recovery. The baby was so fortunate as to obtain the services of a wet-nurse and progressed satisfactorily. The growth was a single soft myofibroma, developing originally from the posterior wall of the uterus, and very edematous. Several points present themselves for consideration:

1. Should the pregnancy have been interrupted or hysterectomy been performed at an early period, saving the months of suffering and its attendant dangers? Not much can be deduced from a single case; and while not presuming to say that every pregnant myofibromatous uterus should be allowed to go to term, the number of cases in which both mother and child have been saved, either by an unlooked-for natural delivery or by operative procedure, would certainly demand strong reasons for the sacrifice of the child either by early hysterectomy or the production of premature labor. In this case the fetus could

not have been removed through the vagina at any time, and nothing short of hysterectomy would suffice; and unless the continued life of the child means almost certain death to both mother and child, I believe the child should have a nearly equal chance.

2. Could the operation have been more safely done from above without the partial removal of the growth by the vagina? I do not believe that the portion of the tumor presenting at the vulva could have been readily enucleated from above so as to allow the wire to reach its proper position, and to apply it at the hour-glass constriction at the level of the sacral promontory would have been to strangulate the whole vaginal mass. The so-called intraperitoneal operation, which has superseded the unsurgical constrictor in the removal of the fibroid or inflammatory uterus, would have been impracticable by the Baer method on account of the nature of the softened tissues, while a panhysterectomy such as we would apply to malignant tumors of the uterine body would have been a most difficult operation under the circumstances.

It was not the death rate which drove us from the extraperitoneal treatment of the stump to the so-called intraperitoneal, but because we found it equally as safe and far more satisfying to every surgical instinct. A combination of circumstances will occasionally arise, however, in which the constrictor will possess positive advantages. Cesarean section after the Sänger method, which has proved so valuable for cases with contracted pelves, could not be considered in this case, as without removal of the tumor there would have lacked the vaginal drainage which is vital to this operation, and the removal of the tumor was a surgical necessity without regard to the pregnancy.

That Porro's operation will always have a larger mortality than simple Cesarean section is self-evident: the necessity which compels a complete removal of the uterus presupposes a seriously diseased condition of the uterus itself, complicating the pregnancy.