ABDOMINAL HYSTERECTOMY FOR MULTIPLE FIBROIDS COMPLICATED BY PREGNANCY.*

BY
J. H. CARSTENS, M.D.,
Detroit, Mich.

(With one illustration.)

FIBROID tumors of the uterus are quite common and now frequently removed without much danger. I will not discuss the great necessity of removing them; of removing them promptly, or watching for general developments. That is out of the province of this paper. I simply want to report a case where I thought it was necessary to remove the growth promptly, on account of the suffering and great distress. The history of the case is as follows:

Mrs. F. B., aged 42; menstruation had appeared at twelve years of age, normal, but with some pain and rather scant when young. Later in life the dysmenorrhea ceased and the flow was rather profuse. Occasionally she had slight leucorrhea. She had always been well, no history of injury or of any abdominal inflammation; in fact, she was never sick, but the last four or five years has had some slight dyspepsia, though a fair appetite. She was inclined to constipation and occasionally took a cathartic. Her father is living at 84, her mother died at 73 of some tumors, did not know where located or what kind. She was married seven years ago and never pregnant. Four years ago she noticed a swelling in her abdomen on the left side in the region of the ovary. This was hard and somewhat movable. She paid no attention to it and it gradually increased in size, extending to the right. The growth did not trouble her and as she was in good

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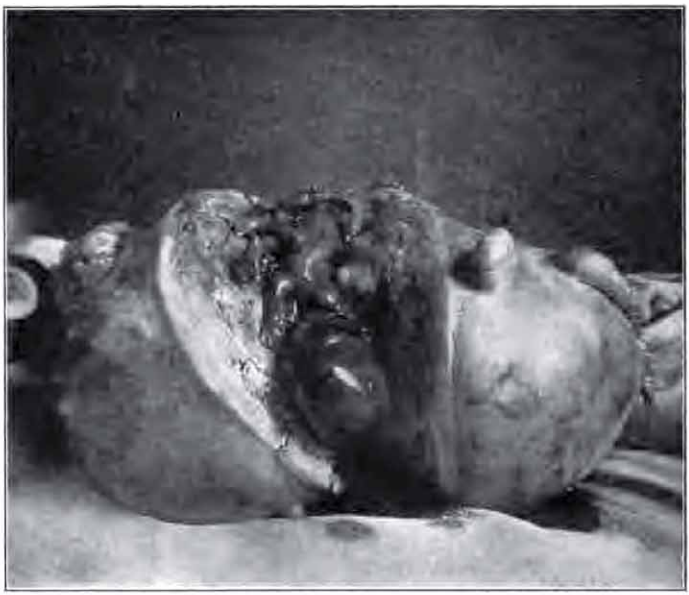
health, she did nothing and consulted no physician about it. Menstruation was regular, but rather profuse until May 4. In June she had slight show and in July she had a more or less slight show for the whole month. Her abdomen now increased very rapidly in size, and she decided to consult a physician. He recognized the growth and urged an operation on account of the rapid increase in size, and brought her to Harper Hospital, where I



examined her and found a large hard tumor filling the pelvis up to the umbilicus. One large growth seemed to be on the left side, another in the cul-de-sac, and small ones could be detected in the lower abdomen. The cervix was shoved forward and high up, and so soft and patulous that I was quite sure she was pregnant. On examining the breasts I found the characteristic enlargement and decided she was pregnant.

It being impossible to deliver her if she went to full term, I

urged a prompt operation and prepared her for the same. August 15, 1905, I operated with the usual technic. There were only slight adhesions and the growth could be lifted out of the adbomen and the supravaginal operation quickly performed. A careful covering of the stump with peritoneum was made and the abdominal incision closed in layers with dry sterilized catgut. The whole operation took only 18 minutes. She was given two pints of saline by rectum, as I usually do in all abdominal sections. She made an uninterrupted recovery, returning home the 18th day.

Examining the growth after the operation, it seemed like any other case of multiple fibroids. Opening the uterus we found a fetus of three months with membranes intact, a photograph of which I here present.

These cases are not very uncommon, still they are sufficiently rare to warrant us in reporting them. If we study their history a few points will strike us. In nearly all instances the woman was sterile, a growth develops, and after some years she becomes pregnant, which naturally makes one suspect that there was some abnormal condition of the uterus, perhaps, some malposition which prevented impregnation, but as the result of the growth, the womb was pulled up or pushed over, in one direction or another in such a way that the ova could pass into the uterus and pregnancy occur. This seems to me the correct explanation of the occurrence of pregnancy in sterile women, after the development of fibroid tumors.

In reference to general rules for this class of cases, I can simply reiterate what I have said on previous occasions: That while no definite rule can be laid down to govern all cases, yet in general:

1. Cases of fibroids complicated by pregnancy can be left alone if they are subperitoneal and located at the upper half of the uterus.

2. Fibroids located in the lower half of the uterus or in the broad ligament should be operated upon.

3. Fibroids adherent or complicated with other pelvic diseases should be removed by enucleation, or in some cases an abdominal hysterectomy should be performed.

620 Woodward Avenue.

DISCUSSION.

Dr. Joseph H. Branham said that cases of uterine myomata were always of special interest. He recalled a patient, the wife of a rather prominent physician, who had a child nearly twelve years ago and had been sterile since that time. She had had two children during her early married life. She was

brought to him about four years ago by her husband, and on examination he found a single large myoma on the anterior part of the fundus uteri. He advised the husband that while he did not consider it absolutely necessary to operate at once, still he thought that if the growth increased in size his wife should be operated upon. The operation was not done, but nearly a year afterwards she again presented herself, with a history of being irregular in her menstruation, and the tumor was growing more rapidly. On examination he was able to detect a tumor of considerable size, which was located in the anterior and upper part of the uterus. The uterus itself with the fundus was turned downward and the cervix upward and forward, where it could be reached with great difficulty; it was large, soft, swollen, the tumor being complicated by pregnancy. It was imperative at the time that an operation should be done at once. The uterus was removed. The operation was uneventful, except that the bladder was opened, but this opening was closed without any trouble.

He had done a number of these operations and this was the only accident he had ever had. He thought he had avoided the bladder in this case, but it was pulled on to such an extent that he made a nick in it before he noticed it.

Dr. Frank D. Thompson, of Fort Worth, Texas, reported a case upon which he operated in 1904, in which there was a large single fibroid in the lower portion of the uterus. The patient was thirty-two years of age, had been married twelve years, but had never borne any children. She was four and one-half months pregnant. The fetus was in the upper portion of the uterus, the large portion being filled with a fibroid as large as a fetal head at full term. Under the circumstances, he thought the only way to save her life was to remove the uterus, and this was done while she was in good condition, with very little loss of blood and without any accident or complications. She made a very prompt recovery.

Dr. Louis Frank, of Louisville, Kentucky, said the treatment of fibroid tumors of the uterus as a complication of pregnancy was a most interesting subject and one which deserved possibly a little more discussion than the members seemed inclined to give it. He had had a little experience with these cases, seeing them at times during the course of pregnancy from the first month up to and even after delivery, and had had to deal with some of the complications that arose at this time.

He was very much opposed to advocating hysterectomy as a procedure to be often advised in these cases without the greatest deliberation and consideration, as his experience had been that many of them went on and delivered themselves normally without any trouble at the full term of gestation, and without any further trouble having ensued. However, there were other cases in which a good deal of trouble had been met with. He had seen two cases comparatively recently in which there were sloughing fibroids. In one of them, a septic case, the fibroid was removed. In the other the tumor had sloughed

almost entirely and the woman recovered without any operation. These cases might look very formidable when first seen, and he had in mind a case that he had reported at a local society, in which it was deemed expedient to do a hysterectomy. The uterus was back in the pelvis so that the presenting part of the child could not be felt. Still, within ten days or two weeks from this time the uterus had risen, a great change had taken place, and the head of the child could be felt presenting below, forcing the tumor out of the pelvis, and the woman had thus far gone on without any trouble.

He had occasion some years ago to deliver a woman three times, in whom a fibroid was present on one side, the tumor producing malposition of the uterus, the presentation being a transverse one. This tumor was not recognized at the first labor, but it was at the second one, and it was believed that there was a second child in the uterus, but careful examination disclosed a fibroid tumor. This disappeared and subsequent pregnancy ensued, with transverse presentation again, and all three children were living, as well as the mother, who now had no evidence of a tumor.

Dr. Carstens, in closing the discussion, thought the question of bringing on labor earlier came up in this connection, yet if one brought on premature labor and had retained placenta, it might be necessary to do a hysterectomy afterwards, which would make the case a formidable one. He agreed with Dr. Frank that in exceptional cases these women should be allowed to go on to term, but ordinarily one should operate on them early. There was little danger attached to the operation.