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THE COMBINED OPERATION FOR THE INTERRUPTION OF PREGNANCY AND STERILIZATION.

BY

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THE interruption of pregnancy at whatever stage and by whatever means is at best a grave procedure. The gravity of the operation does not rest alone in the determination of the indication but as well in the manner of execution. None of the recognized procedures are without danger and experience has taught us that there is an element of uncertainty in all operations.

Where it becomes imperative to interrupt pregnancy for physical conditions which are to remain a lasting obstacle to future child-bearing, the method by which this may be done with the minimum of risk is that first proposed by Sellheim.(1) The procedure consists

of a combination of abdominal hysterotomy and resection of the Fallopian tubes.

The author has performed this combined operation on four occasions and is convinced that the dangers attending the interruption of pregnancy are minimized by removing the ovum through a fundal incision. There is little risk of infection and the dangers of perforation of the uterus and of overlooking placental remains are wholly eliminated. Furthermore, there is a minimum of blood lost and of time consumed in the operation.

Anderes(2) says that in a series of cases in which pregnancy was interrupted and the proposed sterilization was postponed for a future time, it often happened that a second pregnancy intervened before the return of the patient, thus necessitating a second interruption of pregnancy with its attending dangers.

The following technic is employed by the author: 1. Hypodermic injection of pituitrin (1 c.c.) given five minutes before operating. 2. Median abdominal incision. 3. Transverse fundal incision, the incision extending from tube to tube. 4. Enucleation of the ovum with the fingers and inspection of the entire uterine cavity. 5. Closure of the uterine incision by a double row of catgut sutures. 6. Double ligatures passed about either tube with resection of one-half inch of the tube between ligatures and enveloping the severed ends of the tubes between the layers of the broad ligaments. In removing the ovum, the fingers may be reinforced by the placental forceps or a swab of gauze, thereby insuring the complete emptying of the uterus under direct inspection and with the minimum of injury to the uterus.

In the four cases in which the above technic was used, the following indications were presented:

CASE I.—Primipara, aged twenty-three, pregnant eight weeks, presented a combination of active tuberculosis of the lungs and latent tuberculosis of the left hip-joint with ankylosis and marked abduction of the thigh. So great was the abduction of the thigh that it was impossible to dilate the cervix with instruments and the author was forced to do an abdominal hysterotomy for the interruption of pregnancy. Following the emptying of the uterus through a fundal incision, the tubes were resected.

CASE II.—Mrs. L., forty-two years of age, had eleven living children, the youngest one year of age. She was poorly nourished, was suffering from an exophthalmic goiter and a mitral lesion with evidences of incompetency and was in the fourth month of gestation at the time of operation. The combined operation of interruption of pregnancy and sterilization was performed with little or no depression.

CASE III.—Mrs. B., aged forty-three, mother of three children, weighed 228 pounds three years ago, but had lost 100 pounds since that time. She was four months pregnant, had been unable to take nourishment for the past month, and as a consequence was extremely depressed. The posterior surface of the uterus was adherent to the rectum and both ovaries were firmly embedded in adhesions. In the operation the adhesions were severed, one ovary and tube removed, the opposite tube resected, and the ovum removed through a transverse fundal incision.

CASE IV.—Mrs. L., aged thirty-four, para-iv, now in the fourth month of gestation. Patient had lost some 40 pounds in weight in the past six months, was suffering from persistent vertigo, disturbed vision, constant headaches, rapid heart beat, low grade of temperature and increasing weakness. She was kept in the hospital under observation for three weeks. No focal infection could be found, but it was evident that she was suffering from some sort of toxemia. Her condition became increasingly grave. In view of the facts that she was thirty-four years of age, had four living children and that the symptoms antedated her pregnancy by two months, it was determined to execute the combined operation of hysterotomy and resection of the tubes. The convalescence was slow but complete, with the exception of disturbed vision which has not as yet wholly disappeared.

The convalescence of these four cases was more satisfactory than could have been expected from any other method that might have been employed to meet the double indication of interruption of pregnancy and sterilization.

These cases will serve as types of a limited class of cases which call, not alone for the interruption of an existing pregnancy, but for the guarantee that there will be no future pregnancies. It is needless to add that the indication for such a radical procedure must be a permanent disability, wholly incompatible with pregnancy; *i.e.*, incompetent heart lesions, aggravated forms of exophthalmic goiter, active tuberculosis, grave psychoses and chronic nephritis. The procedure is naturally more adaptable to women who have given birth to one or more children.

Fromme and Jaschike argued in favor of the operation in the Fourteenth German Gynecological Congress at Halle, and we find it an established practice in the clinic of Zurich.

Dutzmann reported satisfactory results at the Fourteenth German Gynecological Congress, 1911, in a similar procedure performed per vaginam. A longitudinal incision was made through the anterior vaginal wall, the bladder reflected from the uterus and the vesico-uterine fold opened. The uterus was then drawn forward and opened by a longitudinal median incision, the ovum extracted by means of

the fingers and the decidua curetted. A strip of sterile gauze was passed into the cavity of the uterus and out through the cervix into the vagina. The uterine incision was then sutured, the tubes resected, and the fundus fixed to the anterior vaginal wall. As remarked by Hofmann(3) the vaginal operation of Dutzmann is not applicable to pregnancies beyond the fourth month and is not so free from the dangers of sepsis as is the abdominal operation.

Hofmann reported twenty cases with the following indications: Pulmonary tuberculosis, eleven cases; cardiac lesions with failure of compensation, three cases; chronic nephritis, three cases; renal calculus with anuria, one case; psychosis, two cases.

CONCLUSIONS.

1. The combination of abdominal hysterotomy and resection of the Fallopian tubes is the procedure of choice in all cases not previously infected.

2. The removal of the ovum through an abdominal incision should be reserved for those cases in which permanent sterilization is desired.

3. No other method is so free from the dangers of sepsis, retained secundines, perforation of the uterus and excessive loss of blood.

4. In point of safety, expediency and efficiency the procedure will appeal to all abdominal surgeons.

REFERENCES.

1. *Monatschr. für Geb. u. Gyn.*, Bd. xxxviii, H. 2.
2. *Monatschr. f. Gyn.*, Oct., 1914, Bd. xl, H. 4.
3. *Zeitschr. f. Geb. u. Gyn.*, Bd. lxxv, H. 2, S. 320.

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DISCUSSION.

Dr. Samuel W. Bandler, New York City.—I am very glad that Dr. Findley has called our attention to the indications for interfering with the progress of pregnancy. A rule which I have adopted for myself these many years is as follows: If any patient, who for any genuine reason ought to have no more children, is pregnant, and if her physician in conjunction with me or I in conjunction with another physician feel that she ought not to have any more children, including the one she is going to have, I remove that embryo from the uterus, provided, and only provided, she allows me to sterilize her. So I have followed that procedure in several instances, not however removing the embryo from the uterus by abdominal hysterotomy, but in the usual way and then preventing the subsequent occurrence of pregnancy by an operation on the tubes. In a very early case,

where the patient is pregnant eight or ten weeks, one may safely curet and through a T-incision through the vagna separate the bladder, bring the uterus out and take care of the tubes. When, however, the patient is pregnant three or four months, I curet and do an abdominal operation. There is one little difference in my technic, possibly, and that is, instead of doing as I formerly did, tying two ligatures, resecting between the two, pushing the uterine end in a double fold of peritoneum, I make an incision at the uterine horn and simply close the peritoneum over it. That is a simple method and I feel rather more secure. That method is the one I follow in ligating or resecting tubes in the vaginal operation, the Duhrssen vaginal operation for a total prolapse, where no further pregnancies should be permitted.

DR. FINDLEY (closing the discussion).—I would recommend that Dr. Bandler try the interruption of pregnancy through a fundal incision when he has an opportunity to do so. Most of us, as our experience grows, become less and less cock sure that we can remove all placental tissue by means of the placental forceps, and we are always fearful lest we puncture the uterus, however careful we may be. I do not consume more than twenty minutes in doing the combined operation.