University Med Magazine (U Penn) 1888-89 V-1

REPORT OF TWENTY-FIVE ABDOMINAL SECTIONS PERFORMED FOR THE MOST PART IN THE KENSINGTON HOSPITAL FOR WOMEN, SINCE THE SUMMER OF 1888.

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CAREFULLY made reports of single cases skilfully treated, and critically observed, throughout the whole history of abdominal surgical diseases, from their inception to termination, are always of value, principally in laying a rich foundation for the future collector and analyst, who will thus be enabled to grasp and digest an experience far wider than his individual ken, gathering from the mass of evidence thus afforded the essential traits, and fixing the specific features of the particular morbid processes he may have under consideration.

Of greater interest, however, in the present status of abdominal surgery, are the reports of longer series of cases, in the hands of any single operator of wide experience.

Several useful ends are attained by such reports. The first fact which strikes us in comparing a series of cases, is that the *personal factor* is still very large, and that individual operators must at present be guided by methods largely their own, both in arriving at an opinion as to the necessity for an abdominal section, and when undertaken, as to the manner of its performance. The results of such comparisons are really startling.

In one operator's list great ovarian tumors predominate ; in the next list another has performed an unusual number of hysterectomies for fibroids, another seems to have made a specialty of vaginal hysterectomies, while another has extirpated a disproportionately large number of ovaries for dysmenorrhœa, while a fifth seems to have found nothing but pyosalpinx and pelvic abscesses in his practice, and there seems even to be a tendency to individual specialties in intestinal, liver, and renal surgery, not to mention extra-uterine pregnancy, and Cæsarean section and hysterorrhaphy.

The root of these differences clearly lies in the want of a comprehensive grasp of the whole field of abdominal surgery as it stands to-day.

But if the tables disturb us when criticised from this standpoint, they are altogether pleasing when we compare them with those published even fifteen years ago ; we see at once what a vast number of new and rich fields have been opened up resulting in the complete relief of sufferers afflicted with ailments once incurable, and usually fatal.

We thus realize that we are at present in a *formative* transitional stage, and that our experience is *growing*, but has not yet crystallized in any definite shape.

Still another and not unimportant result attendant upon the reporting of a series of cases is the education of the general practitioner to an appreciation of

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the importance of recognizing in his daily practice cases of abdominal surgical diseases at an early period of their development, by demonstrating the *safety* of surgical interference while the disease is yet localized, even in such desperate affections as cancer and tuberculosis, and the advisability of interference in many diseases not necessarily fatal, but sufficiently painful to render life burdensome, such as intestinal adhesion, myomas, pus deposits, and chronic inflammatory diseases of the ovaries and tubes.

It is also equally important to quicken the appreciation of the laity as to the valuable services capable of being rendered by specialists upon timely appeal. There is an innate horror of an operation which the most intelligent physician often cannot remove, and which demands an abundant evidence of the most practical sort before it will yield.

This last is a fact not so fully appreciated by my confrères, but I realize it now that I am reaping the benefits of the disillusionment in this community in Kensington, where the dissemination, by patients of the Kensington Hospital among their friends, of such facts relative to abdominal diseases and their treatment as they gleaned during their hospital residency, has created a wide-spread interest, and results in the prompt appeal of patients or friends upon the slighest suspicion of any diseased tendency.

The following list embraces twenty-five successive cases of abdominal section without death referable to operation. Neither the cases immediately preceding or following these died.

I begin with the first case which opened a new regime in my hospital, with a better method of preparation of instruments preparatory to operation in the use of dry heat at 140° C., and a bolder technique in the treatment of obstinate pelvic hemorrhage in the ligation of the uterine arteries and veins.

Many cases in this list have been unusually difficult. I hope for these reasons that this brief statement of work for the most part done in the Kensington Hospital will prove of more than ordinary interest.

Short of a complete history, which would be out of place here, but few additional explanatory remarks are called for. One of the most fruitful expedients in saving life and shortening the period of convalescence was that of tying the main trunk of the uterine artery, including the veins for the purpose of checking a persisting hemorrhage.

This was done in Cases 13, 14, 17 and 19, in which the removal of the tumor laid bare the broad ligament down to its base, and exposed its whole uterine attachment. In spite of ligatures a constant oozing kept up until the uterus was grasped at its cornu, pulled well out of the incision towards the opposite side, and a ligature passed with a wide sweep of a large curved needle, embracing part of the left wall of the cervix uteri, and the contiguous broad ligament as shown in diagram B, Fig. 1. In this way the hemorrhage was completely checked.

Case 17 was altogether a remarkable one. A large unilocular ovarian cyst developed in nine weeks. The patient was much distressed at the time of her operation by a story maliciously circulated, asserting that she was pregnant. The operation was one of the utmost difficulty owing to dense universal adhesions. The whole omentum had to be tied

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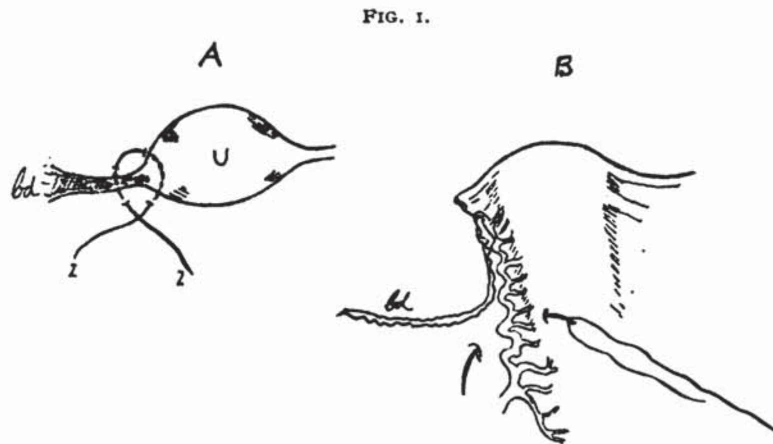
off along the lower border of the transverse colon before the tumor could be handled at all. The uterine artery was secured, as described in the diagrams A and B, and the ovarian vessels close to the pelvic wall.

The abdomen remained scaphoid throughout her convalescence, nor was there the slightest intra-abdominal disturbance. She had, however, an exfoliative cystitis commencing within the first week after operation, and twenty-two days after operation she had a sudden rise in temperature, and developed a mania which has persisted ever since. She has since developed marked tuberculosis.

In Case 14 the omentum was green with gangrene, and was removed close to the colon, with stinking pus and blood. The ovaries and tubes and broad ligaments came away in a great number of rotten pieces. When operated upon she seemed almost dying, with a pulse of 142. The pulse during the operation went up to 162, and remained between 150 and 160 for two days.

FIG. 1.



Showing method of securing uterine artery in obstinate hemorrhage from uterus or broad ligament.

A showing ligature *ll* passing through uterine body (*u*) and base of torn broad ligament (*bd*) embracing uterine artery and veins.
Uterus seen from above.

B shows method of passing same ligature with a curved needle embracing trunk of uterine artery below base of torn broad ligament (*bd*).

This was a good example of a point I often insist upon, that cases of purulent peritonitis, at all protracted, are never *general*, but always limited in their extent. This was the nearest approach to general peritonitis I have seen in any case not tending to a rapidly fatal issue from the very beginning. She is now a strong, healthy woman doing all her own housework.

Case 23 demands a brief explanation. This patient had a large dilated heart, and was in the last stages of the disease. She had repeated attacks of syncope in spite of large doses of digitalis upon which she lived. She became in these attacks more cyanosed than any patient I have ever seen, and it seemed each time impossible for her to survive. Her distress was greatly increased by a rapidly advancing bloody, serous accumulation in the peritoneum. To evacuate this perfectly, I made a quick incision into the peritoneal cavity, under the local anæsthetic influence of carbolic acid. The fluid was completely drained away, and her relief was very great for several days, when her old attacks supervened, and she finally succumbed.

If undertaken sooner, before she had became so much distressed by the pressure of the fluid, the heart would probably have had strength to continue its work a little longer. At the utmost, however, her lease of life was very short.

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DISEASE.	OPERATION.	REMARKS.	RECOVERY.	NAME, ETC.
1. Incarcerated umbilical hernia.	Ring split with scissors, large omental mass removed.	Silk and catgut sutures used. Mass as large as two fists.	Afebrile. Perfect. No tendency to return.	A. K.; hospital; age, 48; married; multiparous; Sept. 27, 1888.
2. Cystic right ovary large as orange.	Extirpation of right ovary with tube.	Had been a great sufferer. Relief since. Left ovary normal.	Afebrile.	K. K.; hospital; age, 22; married; multiparous; Oct. 6, 1888.
3. Cirrhotic ovaries.	Extirpation of both ovaries with tubes.	Fifteen minutes to complete operation. Some adhesions. Closed peritoneum with continuous cat-gut and rest of abdominal wound with silk.	Afebrile. Mild phlebitis which disappeared in twelve days.	M. A.; patient of Dr. Freeman, of North Carolina; age, 35; single; Oct. 13, 1888.
4. Cancerous nodules studding peritoneum.	Two-inch incision into peritoneum. Large quantity of bloody serum evacuated.	Peritoneum and intestines studded with small white nodules, varying in size from pinhead to a split pea. Introduced 20 grs. iodoform into peritoneal cavity.	Late stitch hole abscess from infection from within. Otherwise afebrile.	L. R.; patient of Dr. W. H. Winter; hospital; age, 45; married; nulliparous; Oct. 13, 1888.
5. Retroflexion of uterus with adhesions.	Hysterorrhaphy. Silk sutures used one on each side around ovarian ligaments.	Length of incision 1½ inches. Time of operation 12 minutes.	Afebrile.	A. N.; hospital; age, 33; married; multiparous; Oct. 15, 1888.
6. Pyosalpinx.	Extirpation of left tube and cyst in right ovary.	Operation extremely difficult on account of resisting abdominal walls and numerous dense adhesions.	Afebrile.	M. S.; patient of Dr. A. K. Minnick; private; age, 28; married; nulliparous; Oct. 16, 1888.
7. Strangulated right inguinal hernia.	Ring split. Obliteration of sac.	Disease about 20 years' standing.	Afebrile. Cured.	Mrs. R.; patient of Dr. Shelly, of Ambler, Pa.; private; age, 72; married, multiparous; Oct. 21, 1888.
8. Retroflexion of uterus.	Hysterorrhaphy. Silk suture.	After raising uterus it was found that a suture on one side (r) held it perfectly in anteposition.	Afebrile. Not Cured.	S. A.; patient of Dr. Wiley, of Millville, N. J.; K. hospital; married; multiparous; Oct. 23, 1888.

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DISEASE.	OPERATION.	REMARKS.	RECOVERY.	NAME, ETC.
9. Hæmato-salpinx and blood cysts of ovaries.	Extirpation of both ovaries with tubes. Peritoneum stitched with catgut, rest of incision closed with silk.	Both ovaries and tubes generally adherent. Incarcerated uterus adherent in Douglas pouch and walls glued together, released and raised. Remained erect on tying off tubes and ovaries. Time of operation 30 minutes.	Afebrile.	S. M.; hospital; age, 31; married; multiparous; Oct., 24, 1888.
10. Cystic left ovary.	Large, densely adherent tumor two cysts as big as fists together, ruptured on removal. Delivered only with great difficulty. Broad fleshy pedicle at cornu uteri tied and transfixed.	Had severe ether bronchitis for a week after operation. Threatened pneumonia.	Afebrile. Made slow recovery.	S. I.; K. hospital; age, 38; married; multiparous; Oct. 24, 1888.
11. Fibroma uteri.	Hysteromyomectomy. By new method of extra-intraperitoneal treatment.	Ether produced dangerous cyanosis. Obliged to use chloroform when it disappeared. Bronchitis from ether.	Afebrile. All stitches out in sixteen days.	K. McE.; patient of Dr. L. H Taylor of Wilkesbarre; K. hospital; age 39; single. October 27, 1888.
12. Cystic left ovary.	Left ovary and tube extirpated; raised with great difficulty owing to universal adhesions. Tube spread out over upper surface of tumor. Tumor as large as an orange.	Developed in hilum of ovary. Very broad fleshy pedicle. 30 minutes to complete operation.	Afebrile.	S. R.; patient of Dr. T. van Buskirk; K. hospital; age, 22; married; nulliparous; Oct. 27, 1888.
13. Sarcoma of both ovaries.	Enucleation with tubes.	Both tumors soft, broke down and bled profusely on attempting to remove them; whole of the broad ligaments cleaned out to bases, and uterine arteries tied to check hemorrhage. Drained.	Afebrile. Had to open abdomen same night for hemorrhage from vein in infundibulo-pelvic ligament Uninterrupted recovery. Has scirrhus of pylorus.	A. S.; patient of Dr. A. H. Boyer, of Frankford; K. hospital; age, 44; married; Nov. 15, 1888.

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DISEASE.	OPERATION.	REMARKS.	RECOVERY.	NAME, ETC.
14. Ruptured pelvic abscess. Extensive peritonitis	Removal of whole gangrenous omentum from pubis to transverse colon. Ovaries, tubes, and broad ligaments removed in large number of pieces. Both uterine and ovarian arteries tied.	Pelvis filled with Oj of grumous blood. Everything bound down by adhesions which bled profusely when separated. Pulse during operation 142.	Afebrile. Pulse for first two days from 150 to 160; on third day down to 112.	E. T.; patient of Dr. T. M. Anders; K. hospital; age, 30; married; nulliparous; Nov. 16, 1888.
15. Retroflexion of uterus with adhesions.	Hysterorrhaphy.	Ten minutes to complete operation. One silk ligature passed on either side around ovarian ligament reaching over top of broad ligament.	Afebrile. Complete relief.	M. L.; hospital; age, 28; married; multiparous; Nov. 23, 1888.
16. Cancer limited to corpus uteri.	Exploratory incision to determine extent of disease, followed by vaginal hysterectomy.	Exploratory operation; took 10 minutes; broad ligaments and tubes free; uterus very large and difficult to remove per vaginam. Prolapse of intestines during operation.	Afebrile.	M. F.; patient of Dr. Kubler; K. hospital; age, 45; married; nulliparous; Nov. 23, 1888.
17. Unilocular ovarian cyst.	Cyst removed with universally adherent omentum up to colon, and right broad ligament down to its base; uterine artery tied to check hemorrhage.	Cyst unilocular, containing gluey opalescent fluid, apparently springing from ovarian hilum.	Afebrile. Followed by an exfoliative cystitis. After recovery had sudden fever lasting few hours, followed by mania, from which she has not recovered.	A. C.; patient of Dr. J. C. Crilly, K. hospital; age, 23; single; Nov. 26, 1888.
18. Distressing sense of griping and movements in hypochondria.	Exploratory incision in linea alba in middle of abdomen one third above, and two-thirds below umbilicus.	Abdominal cavity thoroughly examined. All viscera freely examined. Case of peripheral neuritis.	Afebrile.	M. A.; patient of Dr. Wm. Pepper; K. hospital; age, 48; married; multiparous; Dec. 13, 1888.
19. Chronic interstitial salpingitis and ovaritis.	Extirpation of both ovaries with tubes.	Many dense adhesions. Uterine artery ligated on both sides.	Patient had high temperature from an apical pneumonia on right side, followed by double pneumonia. No tympany, no abdominal disturbance whatever. Drained. Now well.	A. W.; hospital; age, 35; married; nulliparous; Dec. 13, 1888.

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DISEASE.	OPERATION.	REMARKS.	RECOVERY.	NAME, ETC.
20. Cirrhotic ovaries.	Extirpation of both ovaries with tubes.	Constant pelvic pain ever since confinement two years ago.	Afebrile, relief at once.	T. K.; patient of Dr. H. Beates; K. hospital; age 23; married; multiparous; Dec. 27, 1888.
21. Tubercular peritonitis.	Exploratory incision. Two gallons of ascitic fluid evacuated.	Time of operation 12 minutes. Abdomen measured 43 inches around girth. Intestines everywhere studded with tubercles.	Afebrile. Abdomen remains flat and patient looks and feels perfectly well.	J. C.; patient of Dr. Hale, of Frankford; K. hospital; age 40; married; multiparous; Dec. 31, 1888.
22. Omental hernia in scar.	Splitting ring in recti and suturing opposite sides together and removal of a fœtid encapsulated suture and hydrosalpinx of right stump, tube left in previous operation, March, 1888.	Drainage.	Some slight localized sepsis from stitch hole abscess; otherwise afebrile. No tympany.	I. S.; hospital; age 29; married; multiparous; Jan. 2, 1889.
23. Hemorrhagic ascites from interstitial hepatitis.	Incision for complete evacuation.	Drained for two days. No anæsthetic given on account of deep cyanosis, and repeated attacks of cardiac failure. Hypodermics of digitalis and brandy.	Afebrile. Much relief until the fifth day, when patient succumbed to one of the attacks of cardiac failure.	S. P.; patient of Dr. A. H. Hulshizer; hospital; age 52; married; Jan. 8, 1889.
24. Ovaralgia.	Extirpation of both ovaries with tubes.	Operation 15 minutes. Had been great sufferer for years, refusing to respond to any treatment.	Afebrile. Complete relief of all pain at once.	L. T.; hospital; age 24; single; Jan. 8, 1889.
25. Ovarian tumors.	Extirpation of both ovaries with tubes, deep ligatures and whipping broad ligaments.	Cysts developed from hilum containing papillomata, one of which had ruptured into the peritoneum. Abundant, thick, opalescent and yellow fluid in cavities.	Afebrile. Drained for two days.	L. F.; hospital; age 32; married; multiparous; Jan. 19, 1889.

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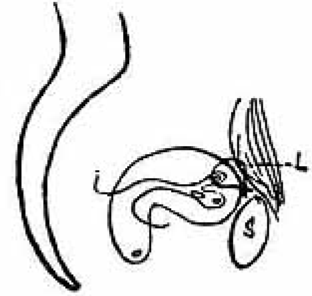
The method which I now adopt in performing hysterorrhaphy, or fixation of a displaced or retroflexed uterus by suture, is worthy of a word of explanation. Where the uterus has been lifted up and attached by the anterior face of the broad ligament to the anterior abdominal wall, by means of two or more sutures in the usual way, I have found that it very often *feathers* backwards, dragging by its weight on its attachments and causing in some instances serious discomfort.

FIG. 2.



Hysterorrhaphy. L ligature tying ovarian ligament to abdominal wall holding uterus in anteflexion.

I have now obviated this difficulty by turning the fundus forwards in a normal anteflexed position, reaching over the top of the tube and broad ligament, and catching the utero-ovarian ligaments of either side in the ligatures, and hanging the uterus to the abdominal walls by these. The result is to elevate the ovaries if prolapsed, to give the uterus a natural posture, and easily retain it, effectually preventing any tendency to retroflexion.

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