COMPLICATIONS DURING AND AFTER THE OPERATION IN A FEW RECENT CASES OF ABDOMINAL AND PELVIC SURGERY.

By William H. Wathen, M.D.,
Louisville, Ky.

While an experienced gynecologist can usually diagnosticate pathological conditions in the pelvis or abdomen that indicate the necessity for an operation, all successful cœliotomists are constantly reminded that it is seldom if ever possible, until the abdomen has been opened, to know just what complications are to be treated in order to complete the operation and save the life of the patient. It is then not always possible to do so. It is exceptional that we find just what we had expected. We anticipate complications that may jeopardize the life of the patient, but the operation is a simple affair; again, we open the abdomen, expecting to complete the operation without difficulty, but conditions are met with that make the procedure a dangerous one, severely taxing the ingenuity of the most experienced cœliotomist. Hence the necessity of never attempting such work until we are thoroughly prepared, theoretically and practically, to treat successfully the various complications that we may encounter. If the operator knows how to treat correctly every abnormal condition in the abdomen or pelvis that surgery can remove, his failure to make an absolutely correct diagnosis is of no serious consequence, if he does honest work. But there is too much cœliotomy done, and too many men are doing it—men who know too little about such work, and have but few facilities. The desire to be known as an abdominal

Digitized by Google

surgeon and to report a series of sections seems to sometimes control the intelligence or the honor of the surgeon, and women with comparatively healthy ovaries and tubes are mutilated beyond redemption, and many of them are made invalids or die, because the operator is ignorant of the correct principles and details that every successful operator must know.

The patients who recover from the immediate effect of the operation are at once published in advocacy of successful cœliotomy, but we hear nothing of the complications that then exist or that are developed later, nor have we always an opportunity to know anything about the numerous cases that die during or soon after the operation. The operator is too enthusiastic and energetic in his efforts to convince other women, probably a little nervous, but otherwise comparatively healthy, with no pelvic exudates or adhesions, that their ovaries and tubes are useless organs, and *dangerous ones*, *too*, for, if not hurriedly removed, a *pus tube may rupture* and cause death within a few hours. We are all familiar with such cases, and there is not a city in the country where several men are doing abdominal surgery that has not one or more operators of which the above is a correct prototype.

It is no uncommon occurrence for women to consult me, saying that a physician had advised the removal of the ovaries and tubes because of extensive adhesions, exudates, or pus tubes, where an examination showed an entire absence of every pathological condition that her pseudo-cœliotomist had so vividly pictured to her. I have written several papers in condemnation of reckless cœliotomy, and have reported many cases in positive proof of the correctness of the position I have assumed, no one of which has been controverted. I could report many more, but the evil is so manifest to all honest and successful abdominal surgeons that it would be a waste of time.

I am pleased to see that many men, with the courage of their convictions, have tried to teach the medical profession the wisdom of conservative gynecology and the evil of reckless and selfish mutilation of women. Among those who deserve especial

Digitized by Google

commendation may be mentioned Polk, Emmet, Mundé, and Coe, of this country, and Wells, Keith, Doléris, and Apostoli, of Europe. Just here I wish to emphasize that I am an earnest believer in abdominal section in properly selected cases, and I know of no department of surgery that has achieved such results or deserves more universal approval and praise.

I am doing a great deal of abdominal surgery, but I always operate for the removal of disease where no other treatment could so certainly cure the patient. And I have probably had my share of success, for I have had no death, and practically no untoward symptom, for about one year, though I have operated on patients where the conditions indicated an unfavorable prognosis.

I do not believe that reported recoveries in simple cases of cœliotomy always indicate superior or unusual skill in the operator; and such reports are of little value to the medical profession, and may indirectly result in the death of many women by influencing ignorant men, with no facilities for such work, to attempt it because of its apparent simplicity.

I will, therefore, report a few selected cases from my recent work, where there was some unusual or troublesome complication to contend with during or after the operation. The study of such cases teaches us to do better work by learning how to treat complications and prevent accidents:

CASE I.—Miss M., aged twenty-four, was referred to me by a well-known surgeon of Missouri, who had diagnosed pelvic abscess on the left side. She was always apparently in excellent health until July, 1891, and had never suspected any tumor or disease in the pelvis or abdomen. At this time she began to suffer severely in the left inguinal region, had accelerated pulse and several degrees of increased temperature. A tumor could be distinctly outlined on the left side of the pelvis, extending into the abdomen. The pain and fever continued for several weeks, but finally subsided, and she thought she was well, and did not examine to learn if the tumor had disappeared. She did not suffer any more, and was apparently well until July, 1892, when

Digitized by Google

she had a recurrence of the pain and fever, and again noticed the tumor. She suffered intensely, and was confined to bed for four weeks, and could not come to Louisville for six weeks. "She has lost twenty pounds of flesh, is still feeble, but has no pain or fever, and is regaining strength. The uterus is nearly immovable, with a tumor in the left broad ligament which seems to be fixed, and connected with the uterus; it extends as high as the umbilicus, and over a little to the right of the median line. A correct diagnosis is impossible, but the necessity for a cœliotomy is positive."

The abdomen was opened August 20, 1892. The omentum was thick, showed signs of extensive chronic peritonitis, and was firmly adherent to all the anterior part of the tumor and to the upper surface of the pelvic structures. When all the adhesions were separated the omentum was so torn and bruised that I removed it above the level of the umbilicus. The tumor was an imbedded broad-ligament cyst, which had not only unfolded the broad-ligament layers of peritoneum, but had stripped this membrane from the posterior pelvic wall to a point above the sigmoid flexure of the colon, separating the layers of the meso-colon so that the mesenteric surface of bowel was attached to the thin cyst-wall. The bowel could be distinctly seen and traced on the anterior surface of the tumor over to the right side, where it dipped into the pelvis and came around behind the womb to the rectum. The uterus was enlarged to three times its normal size, and the peritoneal covering was separated over a large surface from the left side of the body and fundus, thereby exposing its muscular layer. There was no shock, and the patient has made an uninterrupted recovery.

Case II.—Mrs. W., Kentucky, aged forty; married and has several children, the youngest three years old. She is anæmic and sallow; has complained of some pain and pressure in the region of the uterus for six months, but for three months the pain on the right side has been so severe that she has been most of the time confined to bed and has lost considerable flesh. She has not missed her menstrual period until three months ago; since then menstruation has been irregular. The uterus is fixed, and there are hard exudates on each side. The tumor is twice

Digitized by Google

the size of a large orange and reaches on the left side several inches above the pelvic brim. An exploratory cœliotomy was performed on March 27, 1892. A band of omentum, nearly as wide and thick as the hand, was attached to the right broad ligament in the region of the severe pain. It was ligated in two places and divided. The enlarged uterus and the exudates in the broad ligaments were united in one solid malignant mass. No part of the peritoneal surface of the intestines was adherent to the tumor, but the enlarged uterus, with its neoplastic surroundings, had insinuated itself under the sigmoid flexure of the colon, which was attached by its mesenteric surface across the anterior part of the uterus, after the same fashion as in Case I.

She had no pain after the operation, took no morphine, had a normal pulse and temperature, and went home, a distance of fifty miles, in two weeks. She has had no pain since and has gained in flesh, but, of course, the growth will continue to increase, and will eventually cause death.

CASE III.—Mrs. B., Kentucky, aged, twenty-four; married eight months; was well until three years ago, when she was thrown from a buggy and probably received some internal injury. She recovered from the immediate effects of the fall, but has not felt entirely well since.

Three weeks after marriage she had what was diagnosticated as appendicitis and was very sick for several weeks. She had severe pain in the right inguinal region, her bowels could not be moved for ten days, and she vomited a great deal of matter with a very offensive odor. She finally recovered from the immediate effects of the attack, but has had several relapses, and at one time the attending and consulting physicians did not think she could get well. During these attacks her pulse became accelerated, though she had but little, if any, fever. The uterus was in normal position, with some adhesions on the right side. No tumor or enlargement could be found in the pelvis or abdomen, and firm pressure caused no pain. At the earnest request of her husband, a prominent physician, who believed she could not live through another attack, I performed cœliotomy at St. Joseph's Infirmary, June 12, 1892. An incision three inches long was made in the right linea semilunaris. The omentum was exten-

Digitized by Google

sively adherent down to the right ovary and tube, and nearly all the small intestines and some of the cæcum and ascending colon were held together by tough peritoneal adhesions, as were also the right ovary and tube. The pelvic, intestinal, and omental adhesions were carefully separated without injury to any organ, but the omentum was so torn that it was necessary to ligate and remove a piece fifteen inches long and five inches wide and to suture an opening above the ligatures. There was but little hemorrhage and no shock, and the patient was taken from the operating-room in thirty minutes. A glass drainage-tube was used for two days. Before the operation her pulse was 100, but it was not over 90 after it, and on the second day it was 80; it was afterward from 72 to 80. At no time was there an untoward symptom, and she suffered less after forty-eight hours than at any time since the first attack. She returned home, a distance of sixty miles, on the sixteenth day. She has gained flesh and says she is entirely well. The appendix was adherent, but not enlarged or otherwise diseased, and the peritonitis was probably caused by the fall from the buggy.

Case IV.—Miss H., Louisville, aged seventeen; single; began to suffer severe pain in the region of the appendix vermiformis ten days before I saw her in consultation, and had a rapid pulse, and high fever that did not intermit. After the fourth day a tumor could be felt low down in the right inguinal region immediately in contact, and apparently connected, with the ileum. The tumor gradually increased in size, and when I saw her it had extended to the median line and above the umbilicus; her temperature was 105° and her pulse 140. Her bowels moved daily and she had but little tympanites. On August 3 an opening two inches long was made in the right linea semilunaris and nearly a pint of pus discharged, in which was found a fecal concretion, of oval shape, one-third of an inch in diameter by two-thirds of an inch long. It was hard and had a nucleus resembling calcareous matter. The appendix could not be found, and the peritoneal cavity and intestines were shut off from the pus cavity, the outer boundary of which was formed by the abdominal and pelvic walls. It was appendicular in origin, but extra-peritoneal. On the second day the pulse and temperature were about normal,

Digitized by Google

and remained so. The cavity was packed with iodoform gauze, but in a few days two gum drainage-tubes were substituted and bichloride injections were used.

Her recovery was uninterrupted, and the cavity and abdominal wound have closed.

CASE V.—Mrs. H., Louisville, aged thirty-four; married, but has never been pregnant; has for several years suffered such intense and constant pain deep in the pelvis and rectum that she has been unable to attend to her domestic affairs. She has been treated by several excellent physicians, none of whom diagnosticated her trouble or gave relief. There is no disease in the rectum or the uterus, but a tumor of more than fibrous hardness, the size of a turkey-egg, and movable, can be felt deep in the pouch of Douglas and pressing upon the rectum. Cœliotomy was performed August 1, 1892, and a tumor removed from the folds of the left broad ligament with no connection with the ovary or tube. Recovery was uninterrupted, and she says she is perfectly relieved.

By examining the specimen you will see that it is fibroid with extensive calcareous degeneration. While a fibroid tumor with calcareous degeneration in the folds of the broad ligament, having no connection with the uterus, ovaries, or tubes is not unique, it is so rarely observed that but few cœliotomists have probably seen such a case.

CASE VI.—Mrs. H., Indiana, aged forty-four; married, and has three children; has been well, with the exception of indigestion, until a year ago. She then began to have leucorrhœa, the discharge often being in appearance like the menstrual flow. Six months afterward her husband, an excellent surgeon, made an examination and diagnosticated incipient epithelioma, limited mainly to the posterior lip of the cervix uteri. Her condition gradually grew worse, and she was referred to me August 1, 1892. Her general appearance indicated perfect health. Her uterus was retroverted, but not adherent. The epithelioma had extended to part of the anterior lip and on the posterior vaginal wall down to nearly the bottom of the pouch of Douglas. There was no appearance of systemic infection, or that the disease had involved the uterine adnexa or pelvic glands. The uterus was

Digitized by Google

removed August 15 by vaginal hysterectomy, the broad ligament being clamped with Wathen's hysterectomy forceps, which were removed in forty-eight hours. There was no untoward symptom for two weeks, and the patient was sitting up and walking about the room and hall of the infirmary. After the fifth day vaginal injections had been used daily, the water coming away immediately and causing no pain or trouble. She had dismissed her nurse, and on the morning of the fifteenth day another nurse, in charge of convalescing patients, gave her a vaginal douche of a quart of hot 1 : 2000 bichloride solution. But little of the water returned, and she immediately suffered intense pain in the pelvis, which in severity was intermittent, like labor-pains, and at each exacerbation some of the water, which had been forced into the peritoneal cavity, came away. She ceased passing urine through the urethra, and on the morning of the sixteenth day the discharge was nearly all urine, most of which came away during the severe pains. A little urine passed through a retained catheter, the quantity gradually increasing, and after ten days none passed from the vagina, showing that the opening had closed. It was necessary to give morphine hyperdermatically every four hours for several days, and occasionally for a week. She had no fever or acceleration of pulse and no symptom of peritonitis.

I shall offer no explanation to show how the injection caused an opening in the bladder and peritoneal cavity, and report this case mainly to justify an opinion expressed by me three years ago, that the douche after vaginal hysterectomy is no prevention against septic peritonitis, but may convey pathogenic germs and irritants to the peritoneum by forcing the chemical germicide with necrosed tissue into the pelvic and abdominal cavities.

DISCUSSION.

DR. PAUL F. MUNDÉ, of New York.—You are kind, Mr. President, to call upon me to discuss this paper, but I hardly know what to say. The author has related some interesting experiences, and I commend his methods of treatment. I have

Digitized by Google

placed myself on record on several occasions recently in advocacy of conservative cœliotomy, and I am glad to see that Dr. Wathen agrees with me.

He calls attention to the fact that vaginal injections should not be used after vaginal hysterectomy. That is true, and I thought that it was a generally accepted fact. The first vaginal hysterectomy which I performed was four years ago, and I remember distinctly reading the statement by Schroeder that one should, in order not to incur the risk of reopening the peritoneal cavity, forego vaginal injections after hysterectomy.

Dr. A. Reeves Jackson, of Chicago.—The essayist spoke of a surgeon who was surprised on operating to find appendicitis on the left side. Yet within the past year there have been at least two abdominal operations made in Chicago at which the vermiform appendix was found on the left side, and was the seat of swelling and inflammation. The diagnosis in both of these cases was made by competent men, and there could be no question that the appendix had been drawn over to the left side by adhesions, and had there become the seat of appendicitis.

Dr. J. M. Baldy, of Philadelphia.—With regard to appendicitis occurring on the left side, I have only very recently had such a case, the appendix being very long—say five or six inches—and I was able to trace it up to the cæcum. I think that it is a well-known fact that the appendix may be found in any part of the abdomen, either within or above the pelvis.

With regard to diagnosis, I must say that the more experienced I become the greater is the accuracy with which I can make the diagnosis before operating. It is exceptional for a case to come to me in which it cannot be said that the trouble is one of two things. Take twenty-five cases, and one can say in fifteen what the condition is within the abdomen or pelvis; in five others they can say that it is one of two conditions.

Dr. William H. Parish, of Philadelphia.—The paper covers a wide ground, which makes it hard to discuss. Regarding the presence of the appendix on the left side, it may exist there even without adhesions. If there is a long mesentery the appendix may be on the left side, even though it is itself short. Therefore exceptionally the abscess associated with appendicitis is on

Digitized by Google

the left side, or in the median line, but it is more usually on the right.

Dr. Joseph Taber Johnson, of Washington.—I wish to ask the essayist one question: How is it possible in his part of the country to discharge patients as absolutely cured from an exceptionally difficult abdominal section in sixteen days; or how, in another case, was it possible to send the patient home perfectly well in twelve days? It seems to me that those troubles for which we have been criticised so much as being imperfect results following cœliotomy, and especially the occurrence of ventral hernia, can be accounted for largely by allowing the patient to leave the sick-room too soon. The line of incision, in fact, does not become quite strong for a year. I have been very much surprised sometimes on seeing surgeons discharge their patients as absolutely cured by the fourteenth or sixteenth day.

Dr. A. Palmer Dudley, of New York.—The chief point of interest in the paper, it seems to me, relates to diagnosis. I believe that the best gynecologists will continue to make mistakes. I do not wish to arrive at the point where I would be tempted to say the condition was this or that every time, for it would almost surely lead to rashness.

If I remember correctly, one of the cases was that of a fibroid which spread out into the broad ligament on one side of the uterus. In such cases it is difficult to say positively whether one has to deal with a pyosalpinx or a soft fibroid extending out from the uterus, unless, indeed, there is a history pointing directly to a fibroid growth. I have myself seen a considerable number of cases of that kind. Removal is difficult owing to the danger of hemorrhage, but as that question will be discussed later, I shall not speak further upon it now. I think that the author has given us good advice with regard to the vaginal douche after hysterectomy.

Dr. Wathen.—I certainly did not intend to convey the idea that an elongated or otherwise diseased appendix might not be found in any location except its normal anatomical position. We know from experience in abdominal surgery that not only the appendix, but any part of the bowel, may be situated where we had least expected to find it. The cæcum, or transverse colon, with the great omentum, may be found in scrotal hernia.

Digitized by Google

Dr. Baldy surprised me when he spoke of the accuracy with which he makes a diagnosis of the conditions and complications in abdominal and pelvic surgery. As I stated in my paper, there is usually but little trouble in diagnosing conditions indcating the necessity for an operation, but the complications which will be found can only be determined after you have opened the abdomen. I venture to say that nine-tenths of the most experienced operators throughout the world will concur in this opinion. I would like to know how the Doctor could have detected the position of the sigmoid flexure in Cases I. and II.; and how he could, in Case III., have known the extent of the omental and intestinal adhesions, where only a few adhesions could be felt at the right broad ligament. There is no absolute necessity for knowing the exact conditions present until the abdomen is opened, but we must determine the necessity for a cœliotomy.

I did not report these patients as permanently cured as soon as they left the infirmary, for they have since been under observation, but I report them as they were last week. I do not believe in letting patients leave the infirmary, if I can avoid it, so soon as two weeks, and when I can keep them three or four weeks I do so, but this is not always possible. In one of the cases reported nothing was removed and the incision was very short. In the case of cyst of the broad ligament the patient remained three weeks. In the case of extra-peritoneal abscess from appendicitis, an incision only two inches long was made without exposing the intestines, and there was no necessity for keeping the patient longer.

Digitized by Google