

*Vaginal Ovariectomy.* By T. GAILLARD THOMAS, M. D., Professor of Obstetrics and the Diseases of Women and Children in the College of Physicians and Surgeons, New York.

Mrs. S., a multipara of spare habit and remarkably excitable nervous system, had suffered for a length of time from retroflexion of the uterus. For this she had been successfully treated by Dr. James L. Brown, and for the past three years had been entirely free from any rational or physical signs of the condition until four months ago. At this time finding a return of symptoms, due to pressure upon the rectum, she sent again for her physician. Dr. Brown examined and discovered a movable cyst behind the uterus, which, in the erect and supine positions, pushed the fundus uteri forwards and occupied Douglass's cul-de-sac completely. This cyst was equal in size, when first discovered, to a large orange; was painless upon pressure, and could readily be pushed out of the pelvic cavity. Dr. Brown made the diagnosis of cystic degeneration of the ovary, and advised the patient to seek further counsel.

In accordance with this suggestion, Drs. Peaslee, Noeggerath, and myself met in consultation and carefully investigated the case. At this time we found everything in accordance with what has been already stated, and concurred in the opinion of Dr. Brown; deciding still further that the right ovary was the seat of the disease, and that the cyst was in all probability multilocular.

In discussing the subject of treatment three plans were proposed: first, that the cyst should be allowed to develop so that ovariectomy might be resorted to after some years of life had been passed in comparative comfort; second, that the cyst should be tapped per vaginam; and third, that the operation of ovariectomy should be performed through the fornix vaginæ,

in the same manner that it is ordinarily accomplished through the abdominal walls. The last proposal was made by myself, and urged upon these grounds:—

1st. I felt satisfied that the cyst being movable (as proved by the fact that the knee-elbow position would at once cause it to roll out of the pelvis) sufficient space could be obtained through the fornix vaginae to withdraw the emptied sac.

2d. I preferred this procedure to simple tapping, because drainage is very apt to follow paracentesis when practised through the vagina, which might exhaust the patient and prevent a resort to vaginal ovariectomy at a later period. Furthermore, I did not regard the increase of danger attendant upon vaginal section as very great, even if removal of the cyst proved impossible; for in case of such an occurrence I proposed simply to tap the exposed cyst and close the vaginal opening by silver sutures.

3d. I urged the adoption of the vaginal operation rather than waiting for the full development of the cyst, because of the peculiarly anxious nature of the patient. After being informed of the nature of the disease, she thought and spoke of almost nothing else; lost appetite, slept badly, and evidently depreciated in strength. From all that I could learn from her husband, who is a practitioner of medicine, from Dr. Brown, and from my own observation, I thought that she would prove a most unfavourable case for ovariectomy at time of full development of the tumour; and, to repeat a consideration just given in connection with paracentesis, I regarded the tentative process as not attended by great risk, since it involved incision only into the most dependent portion of the peritoneum.

All these views were fully laid before the patient and her husband, and at the end of a fortnight it was decided that the operation should be attempted.

Dr. Brown prepared the patient for the operation by the use of a cathartic, and kept her upon a milk diet for forty-eight hours previous to its performance. On Sunday, Feb. 6, 1870, at 3 P. M., I proceeded to operate, in presence of Drs. Peaslee, Brown, Walker, Purdy, J. C. Smith, and Sproat.

Dr. Purdy having anæsthetized her with ether, she was placed in the knee-elbow position, and secured upon the apparatus of Dr. Bozeman. This apparatus not only completely secures the patient in this position, by straps and braces, but makes the position perfectly comfortable for any length of time, and also favours the administration of an anæsthetic. To prevent all possibility of the rectum falling into the line of incision, a rectal bougie was inserted for about five inches. Sims's speculum being now introduced, and the perineum and posterior vaginal wall lifted, I caught the fornix vaginae midway between the cervix and rectum with a tenaculum, drew it well down, and with a pair of long-handled scissors, one limb of which was placed against the rectum and the other against the cervix, cut into the peritoneum at one stroke.

The first step of the operation being now accomplished, I proceeded to the second. The patient's position was changed to the dorsal decubitus, and passing my finger through the vaginal incision I distinctly touched the tumour, which had now fallen again into the pelvis, and fastened a tenaculum in its wall. With a small trocar I then punctured, one after the other, three cysts, which gave vent to about six or eight ounces of fluid which looked precisely like vomited bile. Drawing upon the cyst, it now passed without difficulty into the vagina.



For the third step of the operation the position of the patient was again changed. She was now placed in Sims's position on the left side and his speculum introduced. Passing through the pedicle at its point of exit from the vaginal roof a needle, armed with a strong double silk ligature, I tied each half of the penetrated tissue and cut off the cyst and ligature. The cul-de-sac of Douglass was then sponged, the pedicle returned to the abdominal cavity, the incision in the vagina closed by one silver suture, and the patient put to bed.

The entire operation occupied thirty-five minutes, and presented no difficulties other than those slight ones incidental to ligature of a pedicle at some distance up the vagina.

Subsequent to the operation the patient was kept quiet and free from pain by opium, sustained by fluid food, and strictly confined to the supine posture. Her only discomfort arose from sleeplessness, and nausea which followed the use of the anæsthetic, and for ten days she progressed without any unfavourable symptom. At this time being allowed to leave the bed and lie upon the lounge she exerted herself unduly, and an attack of peritonitis invaded the right broad ligament. The pulse became rapid, the skin hot and dry, and a phlegmonous mass as large as the fist, hard, and painful to the touch, could be distinctly felt. This soon began to diminish, and now at the end of the thirtieth day has ceased to prove a source of any annoyance, while the general condition of the patient assures me that she is entirely out of danger.

I feel confident that the attack of cellulitis which complicated convalescence in this case was not at all dependent upon the nature of the operation, but was due to indiscretion on the part of the patient in overrating her returning strength.

It is not my belief that the scope of this plan of performing ovariectomy will ever be very great, but I think that in cysts of small size, which are unattached, it will offer a valuable resource for the avoidance of years of mental suffering while disease is progressing, and of the capital operation of abdominal ovariectomy in the end, with all its attendant dangers and uncertainties. Even in a doubtful case, vaginal ovariectomy may be resorted to as a tentative measure, which, in the event of failure from attachment of the cyst, would in all probability be recovered from.

I should urge upon any one who determines to essay it, not to trust to his general knowledge of the anatomy of the fornix vaginæ and peritoneum, but to rehearse the first step of the operation upon the cadaver before attempting it upon his patient. There is often considerable space between the roof of the vagina and the floor of the peritoneum, and it usually requires two strokes of the scissors to penetrate the abdominal cavity. The first severs the vagina; through this opening a tenaculum should be passed, and the peritoneum drawn down and opened. In thin women, if the fornix be well drawn down by a tenaculum, one stroke will often open the peritoneum.

Before operating upon the patient whose case is here recorded, I made one attempt upon the cadaver, feeling confident in my ability to open the

peritoneum with certainty. The difficulty which I met with in this attempt induced me to practise the procedure on seven other dead bodies before I felt willing to attempt it on the living. After the difficulty attending this step of the operation is once appreciated, it can be readily and certainly avoided.