CASE OF

CÆSAREAN SECTION FOR IMPACTED FIBROID.

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Mrs. G——, married ten years; first pregnancy (seven months and a half). Catamenia previously regular (four days); clots; pain. When seen on Aug. 10th, 1887, the abdomen was enlarged, but not as usual in pregnancy, being more rounded on the surface, and more globular in shape. Per vaginam, a hard, immobile tumour, the size of a fœtal head, was felt in the posterior cul-de-sac, with considerable œdema of the mucous membrane over its surface. The os was patent, admitting the tip of the forefinger. The antero-posterior diameter was reduced to an inch and a half. The tumour involved the posterior lip of the cervix. Frequent micturition; no albumen. Dr. John Phillips met me in consultation, and it was agreed that probably nothing but Cæsarean section could be done.

On Aug. 16th, at 4.30 P.M., I operated, with the kind and able assistance of Dr. John Phillips and other medical friends. The abdominal incision extended from two inches above to four inches below the umbilicus; no hæmorrhage worthy of note occurred. The peritoneum was divided in the usual way, and a few ounces of serous fluid escaped on passing the hand into the abdominal cavity. The incision was now enlarged downwards about an inch. The uterine surface presented several fibroid nodules, two of which came directly in the line of probable incision; one a large intra-mural fibroid the size of an orange, occupied the anterior portion of the lower segment of the uterus, so that no opening could be made into the uterus without cutting into it. Large venous sinuses passed transversely over the uterine surface. Attempts to localise the placenta by auscultation and palpation failed. Carbolised sponges were now packed under the flaps of the abdominal incision and the uterus opened by scalpel and scissors, when the placenta was found situated immediately beneath the line of incision. Liquor amnii escaped freely, and the patient was turned on her side. Dr. Phillips kept up the uterine flaps by inserting two fingers of each hand, and effectually controlled the hæmorrhage. I seized the child by the buttocks and extracted; she was born alive, and after twenty minutes breathed freely and cried. The uterus was contracted, there was no further hæmorrhage, the placenta and membranes were peeled off easily, and the uterine cavity explored and packed with sponge. The large tumour was now felt to be quite immovable in the pelvis, and hence any idea of Porro's operation was abandoned. On examining the uterine incision, it was found that it had been impossible to avoid incising three fibroids, including the one already noticed, the anterior uterine wall being the seat of

many. As there was now no hæmorrhage and nothing remaining in the uterine cavity, the sponge was removed, the cavity dusted with iodoform, and the edges of the uterine wound brought well together with deep sutures, the decidual lining membrane being avoided. The largest incised fibroid formed an unfavourable obstacle to adaptation of flaps, and as much as possible was excised. Superficial sero-serous sutures were inserted between the deep ones. The abdominal cavity was sponged out (no blood or fluid had escaped into it), and the abdominal incision closed by deep and superficial carbolised silk sutures. The vagina was syringed out and clots removed; as the cervix was patent, no drainage tube was inserted, but pledgets of cotton wool soaked in glycerine and dusted with iodoform were placed in the canal. The wound was dressed with loose antiseptic gauze and pads, and an ovarian many-tailed bandage applied. The patient rallied rapidly and was quite comfortable, the return of consciousness not being accompanied by vomiting. On the night of operation the temperature was 99·2°; pulse quiet, but variable.

Aug. 17th.—Vagina well washed out; discharge scanty but sweet (blood-stained); facies good; tongue clean; no vomiting. Abnormal tenderness over site of wound, but no flatulent distention. Temperature, 10 A.M., 100·2°, pulse 116; 4 P.M., 100·4°, pulse 116; 10 P.M., 100·8°, pulse 120.

18th.—Slight sickness and tympanites, with an anxious expression. Her condition now gradually became worse, but there was no indication of general peritonitis.

19th.—She died at midnight, with a temperature of 102°, and a pulse of about 140.

Necropsy.—External abdominal wound quite healthy, primary union having taken place. The parietal peritoneum was united, and there was no peritonitis connected with the incision. Uterine wound: Peritoneum united, but for a distance of about three inches around the wound there was deep purple discolouration, more marked on right side than left, this area corresponding in a remarkable manner with that of the placental attachment. The uterine flaps, although in perfect apposition, had not taken on any healing action. The condition of the fibroids in the anterior wall was unsatisfactory, their substance being soft and purulent. The uterus contained a small amount of plum-coloured fluid, which probably could not escape by reason of an unusual condition—viz., acute retroflexion of enlarged uterine body and consequent valve-like closure of exit by fibroid. No effusion of fluid into the abdominal cavity. The large tumour, even after death, was firmly fixed in the pelvic cavity.

Remarks.—A "Porro" was impossible, (*a*) because of the immobility of the tumour, and (*b*) of the cervix being involved. Hence Cæsarean section was done under unfavourable circumstances from fibroid infiltration of the uterine wall; and the question arises as to the proper treatment of these tumours during operation. In the case recorded, incision of three was absolutely necessary; and whether excision of a portion without undue interference with the attachments, or enucleation, offers the better chance appears to be a point to be determined by further experience. It is of much moment, for undoubtedly the presence of these tumours prevented union of the uterine flaps. At a recent meeting of the Obstetrical Society, Dr. Cullingworth advocated free incision of the abdominal walls, extraction of the uterus, and stoppage of hæmorrhage by an elastic ligature round the cervix. In this case Dr. John Phillips controlled the hæmorrhage perfectly with his fingers, and the child was removed by an abdominal incision of certainly less than eight inches, a point of great importance. As to the time chosen for operation, the patient was becoming much distressed, with considerable œdema of both extremities and vulva, and absolute constipation. And it was thought that the prognosis at this period was most favourable for maternal and fœtal life. This is so far justified that the child is now living and healthy, brought up by bottle. The uterine flexion has already been alluded to, and this retroflexion of a gravid uterus by an imprisoned fibroid is a rare condition. The result of this case is disappointing, as all antiseptic precautions were taken, and the operation lasted less than an hour; and it is not easy to see what other course of procedure could have been adopted to avert the fatal result to the mother.