

THE
AMERICAN GYNÆCOLOGICAL
AND
OBSTETRICAL JOURNAL.

JUNE, 1900.

THE MANAGEMENT OF PREGNANCY OCCURRING IN
CONNECTION WITH MYOFIBROMATA OF THE
UTERUS.

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Fortunately fibromata of the uterus cause sterility in the great majority of instances. In fact, sterility is the rule in the submucous variety of these neoplasms,—that is to say, when the tumor is located in the inner layer of the muscular coat of the uterine wall. Occasionally, though very rarely, pregnancy occurs in connection with a myofibroma in the middle layer of the muscular coat, but in most cases of pregnancy associated with myofibromata the tumor is situated in the outer layer of the middle coat of the wall of the uterus. This indicates that the position of these tumors in the structure of the uterus has much to do with the cause of sterility. This may be formulated as follows: In the submucous variety of myofibromata, pregnancy is exceedingly rare, less so in the interstitial, and most common in the subperitonæal varieties.

The size and location of these tumors are also the chief factors in causing the complications which demand special treatment. The presence of small tumors of the subperitonæal variety do not as a rule seriously complicate pregnancy or labor. It is safe as a rule to let the gestation go on in such cases. In the early months of gestation conditions often arise which require attention. The neoplasm generally causes displacement of the uterus, which aggravates the reflex disturbances of pregnancy and prevents the uterus from rising up out of the pelvis as it increases in size. To state this in another way: Myofibromata of small size often produce incarceration of the uterus in the pelvis during the first month of gestation, and if not

relieved promptly, become dangerous. Replacing the uterus and keeping it in the best possible position usually gives relief, and the gestation goes on to time. Labor is not interfered with when the tumor is separated from the wall of the uterus (by the process of pedunculation) sufficiently to permit equal muscular contraction. When the tumor is closely connected with the muscular wall of the uterus, expulsive contractions are inefficient and aid to delivery is required.

I have in mind now five cases of pregnancy accompanied with subperitonæal fibromata that went to full time. In two of them the labor was somewhat tedious, but ended normally; two required forceps delivery owing to inefficient uterine contractions, and one, having a sessile tumor of about four inches in diameter, was delivered by version. All of these recovered and the tumors diminished in size during post-partum involution.

Tumors larger in size than those referred to above are more dangerous to pregnant women. This is especially so when the tumor is connected wholly or in part with the middle layer of the muscular coat of the uterine wall. Such cases never go to the full time of gestation. They either miscarry or die from secondary affections. Miscarriage under such circumstances is very dangerous. I remember several cases of this kind that came under my care years ago and were sufficiently difficult to manage to impress upon me the need for more efficient means of treatment. In one there were several tumors. One, the largest, was attached to the posterior wall of the uterus, several small ones were situated here and there. The patient suffered very little from these neoplasms until she became pregnant. Then she had much pain in the uterus and great nausea. By keeping her quiet and using all the ordinary medical means of giving relief, her physician kept her along until four and a half months. Then she was taken with uterine pain and profuse hæmorrhage. I then saw her and found the cervix undilated. The hæmorrhage was partly controlled by tamponing and the uterine pain made bearable by the free use of anodynes. The hæmorrhage continued, but the cervix was very slow in dilating. The vaginal tampons did not fully stop the bleeding, and in order to arrest it and help the dilatation, it was necessary to pack the cervix repeatedly. When sufficient dilatation was obtained, the ovum presented, but was not wholly expelled so it became necessary to empty the uterus. This was difficult owing to the uterus being high up and crowded forward: but by the use of forceps and scoop, the delivery was completed. The hæmorrhage during and after the delivery was alarmingly profuse, and as the contraction of the uterus was imperfect, it was necessary

to pack the uterus to save the patient from bleeding to death. Considerable fever followed, owing, I presume, to sepsis from the unclean packing and the acute anæmia. The patient recovered, but more by good luck than efficient management.

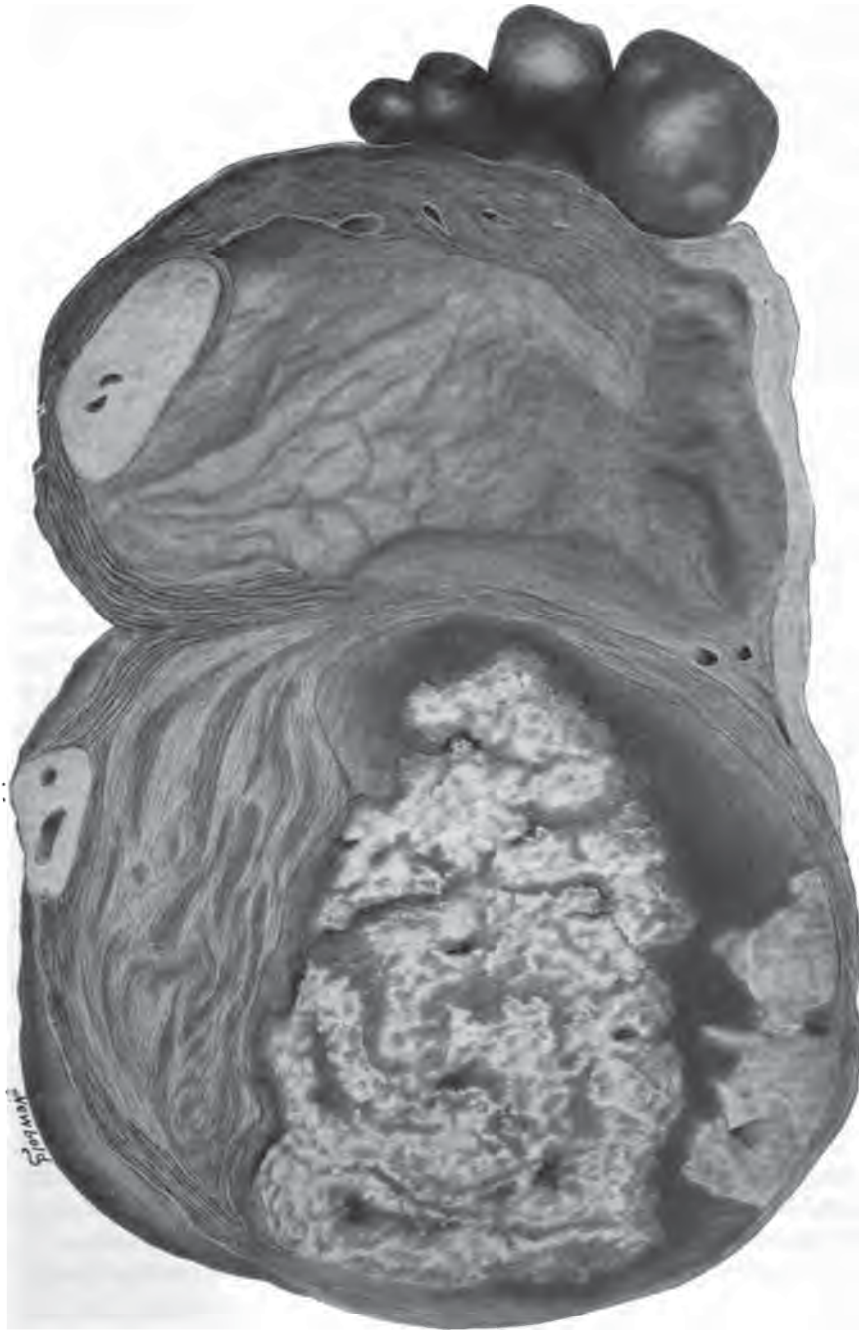
About this time there came another case (having a tumor about the size of an orange) who miscarried at the fourth month. She



began with having uterine pain of a mild form and free hæmorrhage, which had to be controlled by tamponing for over forty-eight hours. Then the bleeding diminished and the pains became severe, and at the end of twenty-four hours more she expelled the foetus and placenta. There were free post-partum hæmorrhages, but they were controlled by ergot and manipulation. The patient was left quite weak and a

mild metritis followed, which continued until she passed from my care.

Bad as these cases were, others far worse came my way. One was the wife of a physician, a delicate lady, who had suffered for years from an abdominal tumor. Her menses stopped and the tumor, which had remained about the same for some years, began to grow faster. The suppression of the menses was attributed to her anæmia and malnutrition, but the rapid enlargement of the abdominal tumor alarmed the doctor. When I saw her first there was a large nodular tumor filling in the lower two-thirds of the abdomen and there was considerable free fluid in the peritonæal cavity. All the nodules or sections of the tumor were round, smooth, and solid, excepting a portion which I took to be the body of the uterus which was somewhat soft, elastic, and obscurely fluctuating. Pregnancy was suspected, but as there were none of the positive signs of gestation present, the doctor did not fall in with my diagnosis. An obstetrician of note was called in, and after several examinations decided that she was not pregnant, but had a fibrocystic tumor or else a fibroid tumor of the uterus and a cystic tumor of the ovary. The tumor kept on growing, and her health failed. The stomach and kidneys did badly and finally some peritonæal inflammation came and ended the life history. At the post-mortem examination, a five months' gestation was found. From the close relations of the tumors to the wall of the uterus and the obstruction of the canal at the junction of the body and cervix, I am confident that the uterus could not have been safely emptied by any efforts on the part of the patient or the obstetrician. This opinion is based upon experiences in similar cases in which the process of emptying the uterus began, but ended fatally. I remember that the late Dr. Lusk presented to the New York Obstetrical Society a uterus with the history that the specimen came from a patient who had become pregnant while she was carrying the tumors presented in the specimen. The gestation went on to about four months and a half. The process of miscarriage began, but progressed so slowly and was attended with such free hæmorrhage that it was necessary to interfere. To empty the uterus was exceedingly difficult owing to its malposition, the deflection of the canal, and its inability to contract owing to the broad and deep attachment of the tumors to its wall. In fact, a portion of the placenta could not be removed by Dr. Lusk with all his expert skill. This portion of the placenta was found in a pocket of the distorted uterus and it was shown in the specimen to be a mechanical impossibility to bring it away. The patient died of exhaustion and sepsis, as I remember the history.



A careful study of the cases given here, and others that have come under observation, has prompted me to classify myofibromata of the uterus in relation to child bearing, as follows:

First.—Submucous tumors, large or small, cause sterility as a rule. (I have only seen one exception.)

Second.—Small subperitonæal myofibromata do not always cause sterility nor complicate child-bearing to a very dangerous degree.

Third.—Interstitial tumors, unless so small that they cannot be detected, and large subperitonæal tumors closely connected with the muscular tissue of the uterus do not cause sterility in all cases, but they are most dangerous complications of gestation, because they predispose to miscarriage and render delivery always difficult, often impossible, and always exceedingly dangerous. This classification facilitated the adaptation of treatment to the indications presented in each class. Therefore, according to present opinions, the first class is to be left out of account in this discussion. The second class requires attention in the first months of gestation in order to keep the uterus in position and aid in its escape from the pelvis up to the abdominal cavity, and finally they may require help in delivery and special protection from post-partum hæmorrhage. The third class demand hysterectomy as the surest means of saving them. This statement is made with a full appreciation of the fact that some cases of this kind have miscarried and lived—hence the extremely conservative practitioners might argue that because a few escape with their lives all should be permitted to take the risk of miscarriage. But in opposition to this is the fact that those who live through a miscarriage are few and that few are left with their tumors, which always impair health and usefulness, and many of them eventually require hysterectomy to save their lives. Now, while I cannot follow the lead of the dangerously conservative and am equally opposed to the daring and aggressive surgeons who see cause to do hysterectomy in all cases of myofibromata which require any treatment at all, I still insist upon the statement already made that all cases of gestation in connection with myofibromata that give no promise of going to full time, should be subjected to hysterectomy.

To differentiate those that should be operated upon and those who should be left alone is not very difficult. By keeping in mind the conditions present in those cases related who went to full time and were safely delivered, and those who failed to complete gestation by miscarrying, correct conclusions can be arrived at with reasonable certainty.

The time to operate in cases which require hysterectomy is still a question for consideration. In general terms it may be stated that when gestation has been diagnosticated in cases of the third class given above, the operation should be done. There are those who refrain from sacrificing a living embryo or fœtus for any reason or purpose, and I am guided by this principle myself to a degree. Therefore, hysterectomy should not be undertaken until there is evidence that the product of conception is no longer living. According to my observation, the embryo died sometime before the end of the fifth month, and when in consequence of this the first indications of a miscarriage appear, then is the time to operate. The following history of a case in point will answer the purpose of a recapitulation of the important facts relating to the subject.

This patient was a well-developed, strong lady who had always had good health. She was 36 years old when she came under my observation, and had been married four years. About a year before this she noticed that her abdomen had become larger than formerly, but having perfect health she paid no further attention to herself until eight months afterwards,—that is, on July 13th, 1899. That was the time for her menstruation, but it did not appear. As she was still quite well, she waited to see if the menses would return, but the amenorrhœa continued and the abdominal enlargement became more noticeable. These conditions induced her to seek advice on September 28th. Her health was excellent, her digestion and general nutrition were normal, and she had no pain or discomfort. At the examination then made, an irregular, hard, nodular tumor was found which extended above the umbilicus about two inches. The tumor was made up of three large masses and several small ones. One of the larger masses was slightly movable upon its attachment to the main body of the tumor; another mass was soft, elastic, and obscurely fluctuating. This mass was in front, and inclined a little to one side. By the vaginal touch the uterus was found to occupy the front of the tumor. The cervix uteri was of virgin size, shape, and density, and the os externum was smaller than normal and was not congested or changed in color to any noticeable degree. The mammary glands had not become enlarged, and though there were changes in the areola, they were not more marked than is generally found in cases of myofibromata of the uterus. There were none of the signs or symptoms of pregnancy present excepting the amenorrhœa and the enlarged and softened uterus,—that is, admitting that the soft mass in front was the uterus.

Fig. 1, a front view of the tumor, shows the relations of the uterus

to the myofibromata. The uterus has been laid open to show the foetus and placenta. The question in diagnosis between fibrocystic tumor and gestation and myofibromata was decided in favor of gestation. The patient continued in good health, but the uterus increased in size so that all doubt about the diagnosis disappeared. She was directed to report at once if there was any pain or hæmorrhage from the uterus.

Irregular, intermittent pain in the uterus came on October 27th and continued for about two days and then subsided, leaving only a slight tenderness. This was taken as evidence that the foetus had died and an effort had been made to throw it off, and that then was the time for surgical treatment. Subsequent examination of the specimen proved this to be the facts in the case. Hysterectomy was performed December 11th, 1899, and the recovery was the easiest and most uneventful that has ever come under my observation.

Fig. 2 represents a section of the tumor including one-half of the uterus with portions of the placenta in position. The uterus is distended, and from the connections of the uterine wall with the tumor, it is evident that the uterus could not contract sufficiently to expel its contents or control post-partum hæmorrhage.

INTESTINAL ANASTOMOSIS; CLAMP AND ENTEROTOME; A MODIFICATION OF GRANT'S ENTEROTOME; AN AID IN SUTURING.*

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The methods employed in effecting end to end, lateral and end to side intestinal anastomosis may be put into three classes:

I. Intra-intestinal Methods.—The severed bowels are coapted and held together by means of plates, buttons, bobbins, couplers, rings, cones, and sutures.

II. Extra-intestinal Methods.—The continuity of the bowel is restored or a new passage for alimentary contents is obtained by the aid of continuous, interrupting or interlocking sutures, that are applied from the peritonæal surface of the bowel.

III. Combination Methods.—In this class intra- and extra-intestinal

* Read before the Chicago Gynæcological Society March 21, 1900.