

TOTAL EXTIRPATION OF THE UTERUS FOR MYOFIBROMA COMPLICATED BY PREGNANCY.¹

BY

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(With one illustration.)

W. D., 27 years of age and married, was seen, in consultation with Dr. W. D. Stewart, April 8th, 1894. Her menstrual history, so far as it gave evidence of an abnormal growth of the uterus, was decidedly negative. Menstruation first occurred at the age of 17, and, except during pregnancy, has recurred at regular monthly intervals. The duration of the flow has been quite uniformly seven days, and the quantity has never been profuse. Three and one-half years ago she was delivered, after a normal labor, of a living child at full term. In February, 1893, she had a miscarriage at the sixth month, labor lasting but a few hours. Since this miscarriage she has occasionally experienced an ill-defined feeling, as of a body moving from side to side in the pelvis and lower abdomen. The last menstrual period began December 21st last and continued for seven days. Six weeks after the cessation of menstruation morning sickness became quite marked and slight tenderness of the breasts was noticed. About four weeks after menstruation she detected a hard mass in the left iliac region, which continuously and rapidly increased in size. Pain, usually mild, but occasionally severe, was quite constant in the lower abdomen. The feet and legs became slightly edematous.

The patient was of slight figure, weighed about one hundred pounds, was five feet in height, and after removal of the tumor measured but nine inches between the anterior superior iliac spines. Examination showed the lower abdomen uniformly distended by a hard, immovable tumor of the uterus completely filling the pelvic cavity and extending to within a finger's breadth of the umbilicus. Above the hard mass, and connected with it

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by a broad base, was a somewhat movable, fluctuating tumor, readily appreciable by the eye, entirely to the left of the median line, extending upward to the ribs and backward into the loin. The lower, hard tumor was extremely sensitive to pressure, while the upper, fluctuating one was so to but a slight degree. The os uteri, firm and patulous, was high up in the left lateral vaginal fornix.

A diagnosis of uterine myofibroma complicated by pregnancy was made. The fluctuating tumor was believed to be either, first, a fibrocyst of the uterus; second, the fetal cavity; or, third, an ovarian cyst carried up by the enlarging uterus.

Considering the high mortality attending pregnancy associated with hard tumors of the uterus, a total extirpation of the tumor and uterus was advised and the patient taken to St. Vincent Hospital on the following day. Owing to the small size of the patient's abdomen, which was even then, at the fourth month of pregnancy, greatly distended, it was not thought advisable to allow the patient to go to full term and to then subject her to a Porro operation.

April 11th the abdomen was opened by a long incision and the tumor turned out of the cavity. Examination showed the lower portion to be hard, smooth, and uniform in outline. From two thirds of its upper surface sprang a soft, fluctuating tumor into which both Fallopian tubes opened. The ovaries were seemingly healthy. The tubes and broad ligaments were greatly elongated and lifted upward as in normal pregnancy. The length of the entire tumor was nearly double its greatest width. No fetal mass could be made out on examination of the cystic portion of the tumor, and the question at once arose as to the location of the fetus. While it was scarcely believed that the lower, hard mass was a normal pregnant uterus at the fifth or sixth month, the possibility of such being the case, and that menstruation might have occurred once or twice after conception, was taken into consideration. To determine, if possible, whether the upper enlargement was a fibrocyst or the fetal cavity, an aspirating trocar was passed through its anterior wall and its cavity until the point could be detected by a finger placed on the posterior wall. Not a drop of amniotic fluid was obtained—simply blood. Hemorrhage from the puncture was quite free, necessitating the insertion of a silk stitch for its control. It was then believed that the fetus lay in the lower portion of the tumor and that the

upper portion was a telangiectatic or cavernous myoma. Believing that, if such was the case, it was better policy to allow the pregnancy to continue under close supervision, bringing on a miscarriage if the necessities of the case required, the tumor was replaced within the abdomen and the incision closed. Had amniotic fluid been obtained by the puncture, the entire mass would have been at once removed. The exploratory incision, the handling of the tumor, and the puncture and suture of its upper portion produced no subsequent results.

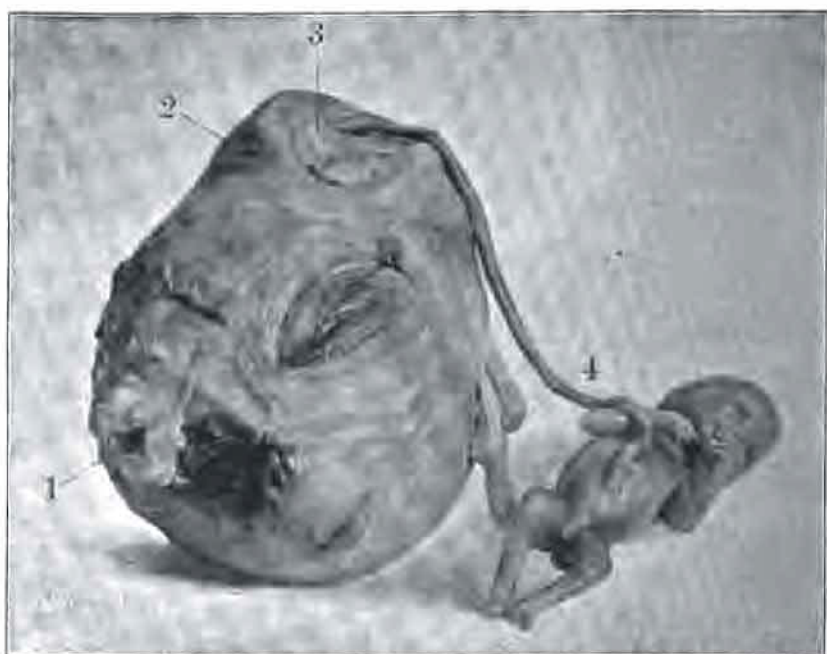
On more deliberate consideration of the case than was possible with the patient on the table and her abdomen open, I became satisfied that the lower portion of the mass was entirely a new growth within the uterine wall, and that the fetus lay in the upper or cystic portion. Strong color was given this view by the fact that both tubes opened into the latter. I then announced to my associates my determination to reopen the abdomen and remove the entire structure as soon as the first incision should have united.

A sound was then passed into the uterus, a procedure which was not considered advisable prior to the exploratory operation. It entered six inches before meeting with the slightest obstruction. No attempt was made to pass it further because of the danger of inducing a miscarriage, which would have been most undesirable.

A few days later, while looking up the very meagre literature of this comparatively rare condition, I found the reports of two quite similar cases. One of these was reported by Mundé in the *Transactions of the American Gynecological Society* for 1884, and the other by Ludlam in the *Clinique* of April 15th, 1894. Both cases were parallel ones with mine, in that a hard tumor was situated in the lower zone of the uterus, while the fetus occupied a cyst-like cavity above the tumor.

Total extirpation was performed April 26th. Although I would not commend as a routine practice the combined method of operation, it was adopted in this case, the uterus being cut free from its vaginal attachment, the bladder separated from the uterus, and the uterine arteries clamped prior to opening the abdomen, thus considerably shortening the time of exposure of the abdominal contents. The abdominal incision was made through the scar from the first operation. Although but fifteen days had elapsed since the exploratory operation, the union of

the fibrous structures of the linea alba was uniformly firm and complete. A few soft shreds of the catgut which had been employed in closing the incision were found still unabsorbed. The peritoneum was adherent to the tumor for less than one-half of an inch on each side of the incision for about one-half of its length. These slight adhesions were readily separated without hemorrhage. The upper portion of the tumor was covered by the omentum, which at one point only was adherent to the line of incision, necessitating separation and the ligation of a bleeding vessel. At no other point were there adhesions between the



Posterior view of tumor. 1, os uteri; 2, wall of fetal cavity; 3, placenta; 4, right tube and ovary.

tumor and contiguous structures. The condition of the silk stitch which had been inserted to control hemorrhage at the point of puncture at the first operation strikingly illustrated the innocuousness of aseptic silk in the tissues. It was completely covered over by a layer of organized lymph, so like in its appearance to the peritoneum that it seemed as though the stitch must have been buried beneath the peritoneum without wounding that structure. No adhesions to the overlying omentum had formed at that point. Both portions of the tumor, but especially the upper, had markedly increased in size, necessitating

an incision eight inches in length, fully two inches longer than had been required fifteen days before.

Having turned the tumor out of the abdomen, the patient was placed in the Trendelenburg posture, the ovarian arteries ligated, an incision through the peritoneum made across the anterior surface of the tumor one and one-half inches above the bladder, and one at a corresponding level across the posterior surface. Separation of the peritoneum from the tumor was then completed, the broad ligaments divided, and the tumor lifted away. The uterine arteries were ligated, the clamps removed, and the ligatures carried into the vagina, which was packed from above with iodoform gauze. With the exception of the ligatures on the ovarian arteries, all were so placed as not to include peritoneum within their grasp. The ligatures on the ovarian arteries were cut short. The edges of the peritoneal flaps which had been separated from the anterior and posterior surfaces of the tumor were brought into apposition by a continuous Lembert suture of catgut, completely shutting off the vagina and leaving all stumps with their ligatures below, and outside of, the peritoneal cavity, with the exception of the stumps of the ovarian arteries. A fold of peritoneum was stitched over the raw surfaces of these stumps, leaving no raw surface within the peritoneal cavity. The cavity was sponged dry and closed without irrigation or drainage. The tumor weighed eight pounds.

The patient made a perfectly smooth and uneventful recovery, without hemorrhage, tympanites, or fever. The bowels were moved on the second day. The vaginal packing was changed on the second day, and daily thereafter until closure of the vaginal vault had occurred. The abdominal stitches were removed on the eleventh day, the incision having healed by primary union throughout.

The serous discharge through the vagina was profuse for the first twenty-four hours, illustrating one of the cardinal advantages of total extirpation—namely, free drainage, to which, I believe, are largely due the remarkably smooth recoveries seen in so large a proportion of the cases of total extirpation.

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