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REPORT ON A CASE OF CESAREAN SECTION FOLLOWED BY HYSTERECTOMY FOR DYSTOCIA DUE TO A FIBROID IN THE LOWER UTERINE SEGMENT.

THIS case is reported as an instance of absolute dystocia due to a hard fibroid mass which occupied the greater part of the pelvic inlet. The patient was 33 years of age, married for the second time in

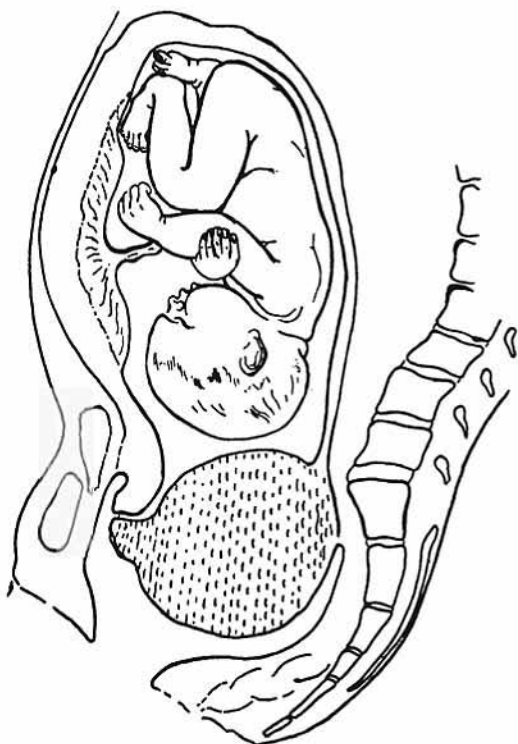


FIG. 1.—Diagrammatic cross-section of trunk showing fibroid below pelvic brim with fetus above.

October, 1912. She had never been previously pregnant and her menstrual history was normal in every respect, there being no menorrhagia present at any time. Her last regular period occurred on February 14, 1913, and on consulting her physician during the last week in April, 1913, the pelvic tumor was diagnosed for the first time. She was advised to have her pregnancy terminated and entered a hospital for this purpose but concluded that as she had no

symptoms from the growth, she would try to carry the child to term.

She was first seen by the writer on September 20, 1913, when an abdominal examination showed the fetus to be about seven and one-half months. The fetal heart was heard faintly around the umbilicus, probably on account of the thick abdominal wall. Vaginal examination showed the pelvis obstructed by a large soft rounded mass above which the fetal head could be distinctly palpated. The cervix was small, moderately softened, not dilated, and occupied a position in back of the symphysis where it could be reached with difficulty. The pelvic measurements were normal. The question of the induction of labor presented itself but as the woman was absolutely free from all symptoms, except a slight abdominal discomfort, it was decided to allow the pregnancy to continue. The patient was seen at regular intervals and the growth of the fundus followed. She was

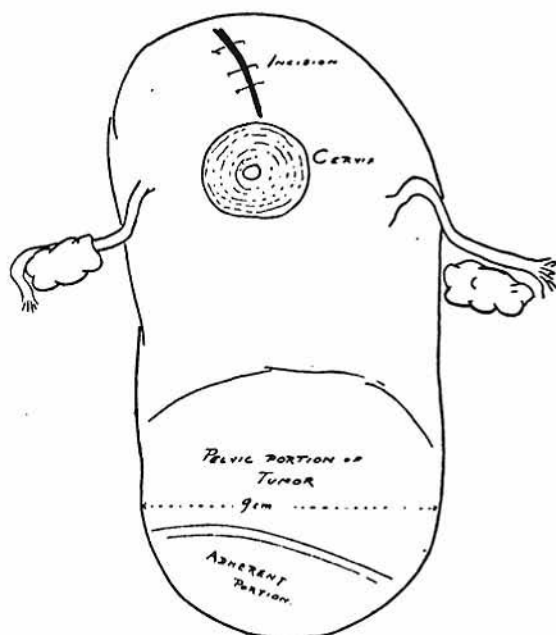


FIG. 2.—View of extirpated uterus from in front showing relation of cervix to pelvic portion of the fibroid tumor.

admitted to the Lying-In Hospital on November 27, the end of the pregnancy having been calculated for November 21. She had irregular and slight pains after a thorough purging with castor oil but no change could be noticed in the position of the tumor, or the dilatation of the cervix. The pelvic mass seemed firmly fixed and it was impossible to displace it. A Cesarean section with possibly a hysterectomy was decided on, and the patient was operated on March 29, 1913. Ether was given by the drop method and one coat of iodine applied before operation. This was washed off with alcohol previous

to making the incision. A hypodermic of ergotole (M. xl) was administered at the beginning of the anesthetic.

In view of the necessity for doing a hysterectomy, the incision was made in the median line below the umbilicus and within three inches of the symphysis. On entering the abdominal cavity the uterus was found to be irregular in shape with firm walls containing a number of fibroid nodules. The peritoneum was loosely attached over the entire anterior aspect of the uterus and the vessels on the surface were greatly distended. The incision in the uterus was made in the median line and the wall found to be a least 2 inches thick. After the cavity was reached the hand was introduced, the membranes freed, the sac ruptured, and the fetus extracted by the breech. It was readily resuscitated. The placenta was quite friable but was extracted completely together with the membranes. Both the placenta and the membranes showed a decided yellow tinge. The cut section of the uterine wall was firm and did not bleed as much as in an ordinary case. There were numerous large and small fibroid masses present over the entire anterior segment of the uterus and the lower portion was likewise made up of a rounded fibroid mass which almost completely filled the pelvis. The wound in the uterus had been closed to stop the bleeding and as the patient seemed in good condition, a hysterectomy was decided on. Anterior and posterior peritoneal flaps were formed and the ovarian arteries on either side tied off. Owing to the presence of bands of adhesions and the varicose condition of the surrounding veins, it was not possible to save the ovaries and these had to be removed with the uterus. In making the posterior flap, the uterus had to be lifted out of the abdomen and this could only be accomplished after the pelvic portion of the same was freed from the inlet where it seemed firmly wedged. A supra-vaginal amputation was successfully done and the cervical stump then sewed over with interrupted chromic gut. After suturing the anterior and posterior peritoneal flaps the abdominal cavity was closed in layers. The patient's pulse began to go up in the early stages of the hysterectomy and a 1000 c.c. of salt solution was introduced under the breasts. On the left side the descending colon was bared because of its adhesion to the uterus but this was carefully sewed over and gave no further trouble. The patient made a perfectly uninterrupted recovery with the exception of a slight pyelitis which developed in the second week but rapidly subsided. She left the hospital at the end of the third week, both she and the baby being in excellent condition.

The case, with the specimen shown, demonstrates conclusively the inadvisability of waiting too long in the presence of this form of dystocia before resorting to a radical operation. The question of doing the hysterectomy at a later time seems to be answered by the favorable recovery which resulted in this case in comparison with the possible sloughing and degeneration which might have occurred in this fibroid mass had it not been removed.