

FIBROID TUMOR COMPLETELY OBSTRUCTING UTERINE CANAL; DEAD FETUS LONG RETAINED WITHOUT INFECTION.

BY

O. G. PFAFF, M. D.,

Indianapolis, Ind.

(With one illustration.)

IN connection with the report of a very unusual case of uterine fibroid complicating pregnancy, I wish to call attention to a series of collated cases which present numerous interesting features of a somewhat similar character.

The first is a demonstration by Hartog(1) of a submucous cervical myoma the size of a child's head, weighing 1250 grams, which was enucleated during the placental period. The patient was a woman, thirty-eight years of age, pregnant with her fifth child, who was admitted to the clinic after three days of ineffectual labor pains. Immediate extraction of a dead child per vaginam was performed. Extremely profuse hemorrhage ensued and manual detachment of the supposedly adherent placenta was to have been performed for control of the bleeding, but on introduction of the hand the passage to the uterine cavity was found to be blocked by a tumor as large as a child's head, which was broadly inserted at the upper cervical segment on the right side. It was interpreted as a submucous myoma. The placenta was reached with difficulty, alongside of the tumor, and was extracted as a whole. Although the uterus contracted satisfactorily, the hemorrhage continued and became alarming. It was, therefore, decided to extirpate the myoma and the enucleation was successfully accomplished. As the hemorrhage stopped, no further operation was performed; especially as no perforation could be discovered on careful examination. Patient was given camphor and an infusion of 1000 c.c. salt solution, and her general condition visibly improved. After about one hour the hemorrhage reappeared and could not be controlled by massage. Patient's general condition became rapidly worse and the pulse was temporarily imperceptible. Soon after the uterus had been tamponed as an emergency procedure, the patient died, two hours after delivery.

Rosenstein, in the Breslau Gyn. Society, referred to a case under his observation in which a large cervical myoma was mistaken for an ovarian tumor. Rosenstein performed laparotomy and induced

artificial labor by means of a bougie. The resulting pains had the effect of wedging the myoma into the small pelvis, thereby causing total intestinal obstruction. Seemingly no alternative was left but the vaginal removal of the pregnant uterus together with the tumor. This was successfully accomplished and the patient made a good recovery.

Zangemeister(2) presented a myoma of the parturient uterus obtained by operation. The myoma had attained the size of a large fist and blocked the pelvis of the patient, a primipara thirty years of age. A living child was obtained through Cesarean section. At the operation the uterus appeared to be in imminent danger of rupture and supravaginal amputation was performed, followed by detachment of the myoma. The uterine cavity contained gaseous, purulent, amniotic fluid, colon bacilli and streptococci. An uneventful recovery ensued.

Fuchs(3) performed a Porro operation upon a primipara forty years of age, on account of a myoma acting as an obstacle to delivery. Mother and child were discharged well on the fourteenth day after the operation.

This case of Fuch's presented certain noteworthy features, aside from the rapid growth of the myoma, which *during six months of the pregnancy reached about three times its original volume.* The topographical relations of the tumor to the pregnant uterus (the anterior uterine wall being the seat of the tumor) led to an extreme bulging of the posterior uterine wall, still demonstrable in the fifth month. The rising uterus did not drag the myoma along, as had been expected, but by virtue of its subperitoneal location the myoma continued to develop downward into the pelvis where it finally became an irreducible birth obstacle. Spontaneous expulsion with the labor pains failed to occur. The fetus came to lie in a transverse position in consequence of the obstruction at the pelvic inlet. Cesarean section seemed positively indicated. The conservative Cesarean section alone, leaving the tumor behind, would have exposed the myoma to the danger of necrosis during the puerperium, especially as it extended near the lower birth passage. At any rate, the patient would have had to submit to another laparotomy later. Cesarean section with enucleation of the myoma would have created less favorable conditions of the wound than the procedure which was selected, namely, supravaginal amputation which fulfilled both the obstetrical and the gynecological indications and resulted in recovery.

An interesting report was made by Carmichael(4) of the case of a primipara forty-two years of age; a myoma the size of an apple was removed from the uterine fundus, through a laparotomy incision, in

the fifth month of pregnancy, on account of severe pains. A larger myoma was found to be in the cervix, presumably an insuperable obstacle to spontaneous delivery. This was not disturbed and the pregnancy progressed without interruption, and at term the patient was delivered of living twins, through Cesarean section followed by hysterectomy.

Volmat(5) refers to the case of a primipara, forty-three years of age, who was found to have a large myoma the size of a child's head,



FIG. 1.

solidly wedged in the pelvic inlet; the child lay above it in transverse position. The pregnancy took an uninterrupted course. At the end of the ninth month, in the absence of labor pains, Cesarean section was performed, followed by hysterectomy. Mother and child made good recoveries.

Fothergill(6) describes a case in which the fibroma was applied to the anterior wall of the uterus, very low down, absolutely blocking the pelvic inlet. Mother and child were both saved through Cesarean section.

G. A. Hendon(7) enucleated a fibroid tumor by laparotomy and discovered a four months' pregnancy; the woman aborted in twenty-four hours, but made a good recovery.

Schrenck(8) observed the combination of two subserous myomata, the size of a fist, with normal pregnancy. Delivery at term with forceps. Atonic secondary hemorrhage followed, but good recovery resulted.

The interesting case which I will briefly report is as follows: A colored woman, thirty-five years old, was admitted to the Indianapolis City Hospital, Oct. 7, 1914. Unfortunately a very meager history was obtained and the patient could not be located after leaving the hospital. She was a multipara and had usually enjoyed fair health; there was no history of an acute infection, nor of any inflammatory attacks. She had complained only moderately of pelvic soreness and backache. Examination before operation showed a uterine tumor of good size which presented two large bosses. *Clinical diagnosis*—fibroid tumors of the uterus. Operation, Oct. 13, 1914. Dr. O. G. Pfaff; supravaginal hysterectomy; left tube and ovary not removed.

Gross Description of the Specimen.—The specimen consists of the fundus of the uterus together with the right tube and ovary. It measures about 7 inches in length and presents two tumors. The lower is about 5 inches in diameter, is very elastic and firm. The upper, which is situated somewhat in front of the lower, is about 2 inches in diameter and gives a sensation when palpated like that of parchment. It appeared to be a calcareous structure. On medial longitudinal section, the lower tumor is found to be a large submucous fibroid measuring on an average of 4 inches in diameter and bulging into the cavity of the uterus which is distorted to accommodate it. The small crepitant tumor above is found to be the skull of a partially macerated fetus which is still attached by the umbilical cord to the remnants of its placenta. The skull measures 2 inches in diameter and is covered by a thin coat of uterine muscle. The brain has been reduced to a grumous material resembling thin cottage cheese. No amniotic fluid is present. The ovary and tube are normal. *Diagnosis*—submucous fibroid tumor blocking the outlet of the uterus; macerated fetus. *Microscopic sections* of the tumor were made which show nothing of special interest.

The pregnancy had evidently been interrupted many months previously and indeed the appearance of the fetus suggested that it might have been present in its peculiarly isolated and protected position for a term of years, infection having been obviated by the mechanical occlusion of the greater part of the uterine canal. Uneventful recovery ensued.

My chief thought on this subject is that mechanical obstruction of the birth canal, due to the presence of fibroid tumors, is sufficiently common to merit that degree of appreciation at the hands of the

family doctor which shall lead to a more intelligent activity in efforts to prevent the serious and sometimes disastrous complications which result in such cases when pregnancy occurs. We all concede a general familiarity with the subject but to consider the matter in a purely speculative way is hardly sufficient. The study of specific cases should be of much greater value, and may in turn enable us to present to the medical attendant in a more convincing form the reasons why, even the smaller fibroids, should be sought and removed. One may easily lose sight of the fact that a small tumor frequently undergoes a considerable and sometimes very great enlargement during pregnancy, and that to ignore the presence of these neoplasms is to determine that the individual must in the event of pregnancy assume a grave and unfair hazard and one which she might be readily spared through a timely surgical operation.

BIBLIOGRAPHY.

1. *Monatschrift für Geburtsh und Gynaekol.*, vol. xxix, 1909, p. 431.
2. *Monatschrift für Geburtsh und Gynaekol.*, vol. xxvii, 1908, p. 402.
3. *Monatschrift für Geburtsh und Gynaekol.*, vol. xxxiii, 1911, p. 229.
4. *The Journal of Obstetrics and Gynecology of the British Empire*, vol. xxiv, No. 2, 1913, p. 124.
5. *Bulletin de la Soc. d'Obst. et Gyn. de Paris*.
6. *British Medical Journal*, Nov. 8, 1913, p. 1230.
7. *Am. Journal of Surgery*, vol. xi, 1913, p. 429.
8. *Deutsche Med. Wochenschrift*, vol. xxxi, 1913, p. 1525.