

CASE OF
EXTIRPATION OF UTERUS AND OVARIES
BY ABDOMINAL SECTION.

COMPLETE RECOVERY.¹

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I WAS requested by Mr. Goss in October last to see with him in consultation Miss A—, aged thirty-six, a young person of fair complexion, anæmic, and somewhat fragile-looking, suffering from an abdominal tumour. She had had two attacks of rheumatic fever during her last decade, and suffered from retention of urine periodically, which she states first set in thirteen years ago, when a hard lump was first noticed over the pubes. This lump grew by degrees, year by year assuming large proportions, accompanied by excessive menstruation; but during the past two years the growth had become so rapid, and was attended with such alarming menorrhagia, lasting two weeks, sometimes three, and of late a month at a time, that she grew nervous, became alarmed and faint, and frequently sought advice. Menstruation had begun at fifteen, ceased at seventeen to nineteen, and subsequently became irregular. Constipation had been most troublesome, and three weeks would elapse without passing a stool. During the last two years no stool had passed without taking large doses of Epsom salts, and her life had become a burden from mechanical weight and pressure.

On close examination "a large globular tumour" was felt in the middle line, occupying nearly the whole of the abdominal cavity, extending from the pubes to within two inches of the ensiform cartilage, smooth, hard, and stone-like, movable, rotating freely from side to side; and on the left aspect a sausage-like body was felt, which receded from the grasp of the fingers. The size of the growth was that of an eight months' pregnant uterus, and very closely resembled it. The girth of the abdomen around the umbilicus was thirty-six inches. Vaginal examination showed the uterus drawn up and the passage elongated, the cervix small, curved forward like a bent thumb, and the sound passed in for an inch and a half with difficulty. On rotating the tumour externally, the cervix was felt to move with it in every direction most freely, but the rectum and bladder were uninfluenced by the movement. We concluded, therefore, that we had to do with a large uterine myoma; that the sausage-like body was either a cystic condition of ovary, or adherent intestine. That we had no ovarian condition to deal with we felt certain, but a solid uterine tumour with no pedicle; and that nothing short of absolute extirpation of the whole organ should be entertained, if entertained at all. This condition was fully put before the patient and her friends, and after due deliberation the patient assented to the operation.

Having a well-defined mitral bruit from rheumatic endocarditis, we chose ether for the anæsthetic; and on Oct. 26th, 1884, we operated, assisted by Mr. Craddock, Mr. Lowe, and Mr. Roberts, Mr. Terry giving ether. An incision of six inches was first made below the umbilicus, and prolonged for three inches and a half more above towards the epigastrium. There was an escape of a fair amount of ascitic fluid, and we came at once upon the dense uterus. Passing the hand round the organ, a few adhesions of omentum and bowel were met with, torn through, and ligatured with chromic silk, and the uterus was raised out of its bed through the external wound, and a loop of strong carbolised whip-cord was passed through the fundus to hold and keep it in any position that might be required. The interest in the adhesions lay in the cæcum being closely attached to the right portion of the cervix, and the vermiform appendix being coiled like a lumbrical worm round the cervix posteriorly in the exact spot we chose for section. Luckily it was made out, separated carefully, passed back, and held in the iliac fossa. The fundus of the uterus was found to have absorbed nearly the whole of the cervix supra-vaginally. The ovaries on each side were multi-cysted, and each was about the size and shape of a Cambridge sausage. The broad ligaments were stretched, thinned, and very vascular with

veins, which ran over the front of the uterus. The rectum and bladder were found non-adherent. Bearing in mind the method practised by Sir Spencer Wells, we attempted to separate the peritoneal capsule covering the organ, with the view of obtaining a perfect peritoneal covering for the stump, and we succeeded in separating the anterior portion back to the broad ligaments; but we could go no further, and we abandoned this method, and then determined to clamp the thickened cervix, to divide it, and bring the pedicle outside. The vascular broad ligaments were transfixed with carbolised silk on one side and chromic silk on the other, cut through with scissors, and dropped back into the pelvis. Passing the index and middle finger in front and behind the cervix, to keep the bladder in front and the ureters (which, by-the-bye, lie immediately in contact with the posterior surface of the cervix behind) out of the way, we passed Lawson Tait's new copper wire clamp around the neck, ran up the screw, fixed the nuts, and proceeded to screw the clamp home with considerable force. Finding the cervix, which at this point was four inches in diameter, firmly and tightly held and secured, the uterus was cut through with a curved bistoury about an inch above the point gripped by the clamp. There was no hæmorrhage, and the cavity of the uterus (into which on section a little finger could be passed) was so tightly compressed that all traces of it disappeared. The pedicle was brought outside, and it is known that Tait's clamp requires no pins to support it externally; and a Keith's six-inch glass drainage-tube was placed, not in Douglas's pouch, as in ovariectomy, but in a more dependent portion of the abdomen below the stump, between it and the bladder; and to this position of the tube, I believe, we owe this woman's recovery. The intestines were well washed with eucalyptus lotion (1 in 30), and alternately placed carbolised and chromicised ligatures brought together the abdominal parietes. The stump was encircled and dressed with boric lint soaked in Friar's balsam; dry dressings of Gamgee's tissue were applied, and she was removed to bed apparently suffering but little from shock, although the operation had lasted nearly two hours, and she had taken five ounces of ether.

On being put to bed in blankets, the patient's pulse was 72, respiration 32; and six hours after her temperature stood at 99.2°, pulse 64, respiration 32; and for four subsequent days the temperature did not exceed 100°, or the pulse 80. For sixty hours after the operation nothing was given by the mouth except iced water and an occasional teaspoonful of brandy, and some cold tea. Twenty-four hours afterwards, a 4 oz. feeding enema of beef-tea and two drachms of brandy were ordered every six hours, and continued steadily for several days. Six hours after the operation sixteen ounces of urine were drawn off by catheter, and we then knew the ureters were safe from the clamp. Forty-eight hours after the operation the stump was dressed with strong eucalyptus vaseline, and four drachms of limpid serum drawn off from the glass tube. On the evening of the fifth day her temperature rose to 102°, pulse to 96, and then the discharge began and continued to stink like an autopsy for six continuous days. The stump then commenced to discharge pus, but the peritoneum seemed adherent around it everywhere. Accordingly, a 1 in 30 eucalyptus lotion cleansed the stump, and we dressed it with eucalyptus vaseline. The tube was washed out with some of the same eucalyptus fluid, and half an ounce left in, which always disappeared by the next dressing, which was done every four or six hours, and the stump was pared down with scissors as closely as possible to the clamp. Although the peritoneum seemed to be shut off around the stump, we felt that the foul fluid drawn from the tube leaked down somehow, and we never left the tube alone as long as it smelt. As the stump sloughed, we dusted on dry iodoform for a few days, but dripping perspirations and nocturnal delirium ensued, which pointed to iodoform absorption, and we had reluctantly to abandon its use, when the delirium subsided. The tube ceased to smell on the twelfth day, and the temperature fell. With the exacerbation of the symptoms on the fifth day, we ordered minute doses of calomel and opium, and quinine in ten-grain doses every four hours; and she took milk in large quantities and digested it well. The bowels were moved on the ninth day, and occasionally they became troublesome and irritable from the quantity of milk taken, and there was sometimes painful flatulence and some tympanitis, which required the use of an O'Beirne's tube. She took meat at the end of the second week with bitter beer, and

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liked it, and her appetite from first to last never failed her, as she was never sick during her illness. The carbolised stitches in the parietes were removed on the eleventh day, and were found rapidly disintegrating from the action of leucocytes; but the chromic acid sutures were all intact, and were allowed to remain *in situ*, some till the eighteenth day, and the last to the twenty-first day after operation. These were all unchanged in texture, in contradistinction to the carbolised silk. The glass tube was thrust out bodily on the thirteenth day, and the clamp, after becoming bent and turning completely over, from retraction of the stump, separated, and came off on the eighteenth day, leaving a chasm into which we could thrust our four fingers, but quite shut off from the abdominal cavity. The patient continued to make steady progress, and the abdominal walls were quite firm at the end of a month. The site of the stump required a good deal of attention, but it gradually filled up; and two days ago I found the remains of a cicatrix measuring six inches only, and a sulcus, the site of the pedicle, not larger than a pea; and the abdomen, no longer retracted towards the promontory of the sacrum, had become quite smooth, like an ordinary ovariectomy. On examination per vaginam, the portion of the cervix remaining was felt to be no longer than the first phalanx of a thumb, quite shrivelled and drawn upwards. She now no longer requires Epsom salts, for her bowels are quite regular; and she walks about at the present time, fat, well, and stronger, she says, than she has been for years.

Remarks.—I feel tolerably certain this young person owes her recovery to drainage and the constant application of the aspirating syringe with eucalyptus fluid into the abdominal cavity. This case has further taught me that in hysterectomy we cannot have too much drainage about and around the stump. We placed the tube in this case below the stump, between it and the bladder, and consequently caught up all the septic fluid from the most dependent situation, and in another like case I would have a second glass tube above the stump in the direction of Douglas's pouch. Luckily at no time did we have any hæmorrhage, and I hold that Wallace's plan of giving nothing by the mouth until the third day reduces the tendency to vomiting and to paralysis of the bowels to a minimum, and consequently recommends itself. Experimentally, we used the chromic silk suture prepared by boiling China twist in a 2 per cent. solution of chromic acid for a few minutes and soaking subsequently for twelve hours, and we found it answer admirably. We tied our broad ligaments and Fallopian tubes with it, and several bleeding points within the peritoneal cavity, and we used half chromic sutures and half carbolised for the abdominal parietes, with the result that the chromic ones were unaltered at the end of three weeks, producing no irritation in their track. There were several around the pedicle, but what became of them I know not. I never troubled about them. I produce in a bottle a sample of chromic twist which was in the belly for twenty-one days. We had another object in view in keeping these sutures in twice the usual time. Küster has shown that buried sutures answer well in laparo-myotomies in producing resistant cicatrices, and he points out how frequently in the best hands ventral hernias follow abdominal sections. Neuber and Schroeder practise the same method also with much success, and in chromic twist I believe we have the material that will answer the purpose for further experimental research. With one single exception hysterectomy has a fearful mortality. Sir Spencer Wells has 50 per cent. of deaths, Lawson Tait over 35 per cent.; and Bigelow of Washington stated a year since that out of 359 of these operations there were 227 recoveries against 132 deaths. But Dr. Thomas Keith of Edinburgh alone has had good results—that of 8 per cent. He has used the intra-peritoneal as well as the extra-peritoneal method, and he wisely points out how much each case must be a law unto itself. I have no doubt the operation of the future will be extra-peritoneal; and the future must show how shock, hæmorrhage, and septicæmia can best be avoided during the operation and in the subsequent treatment. Dr. Matthews Duncan, in writing to me recently on this case, urges the absolute necessity of selecting these cases as the only sure guide to success, and he believes Keith's results have been brought about only in this way. I will not enter upon Listerism here—it has been thrashed out well enough elsewhere; but absolute cleanliness with instruments, sponges, and dressings is the point. We turned off the spray after keeping it going in the room for

one hour before we opened the abdominal cavity. The growth removed weighed $10\frac{1}{2}$ lb., and included uterus, ovaries, and Fallopian tubes. Microscopically it showed the ordinary structure of a uterine myoma. It is only right to add, that this patient was treated under the best possible conditions, in a private house at Lansdown, away from all possible contagia; and I cannot refrain here from saying how much she owes her recovery to the unwearied devotion and pains in carrying out rigidly the treatment agreed upon to my friend, Mr. Lowe, the late house-surgeon of the Bath United Hospital.

TREATMENT OF MANIACAL EXCITEMENT¹

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IN compliance with the wishes of the President of our section I offer some remarks on this subject, and though the paper I bring before you to serve as an introduction to the discussion is faulty and imperfect, yet I trust that even its faults may have an effect in promoting discussion. The *raison d'être* of a discussion such as is intended to take place in our section is to elicit from those engaged in the treatment of cases presenting the phenomena of maniacal excitement their matured views, the result of their own experience on all that concerns the subject, cure or alleviation being the points specially kept in view. In dealing with the subject I purposely avoid quotations from text-books; and in venturing to give some of the results of my experience, I do so trusting, in exchange, to hear matters of greater value from those I see here. I have always held that, as asylum physicians, we scarcely interchange opinions sufficiently minutely in regard to modes of treatment, and that, owing to this, minor improvements might fail to come under our notice; and I have at times endeavoured, but without success, to elicit from one or two of my northern brethren, who rather pose as reformers of asylum treatment, some accurate statements of new and much-praised modes of dealing with the insane adopted by them. I therefore observe with pleasure the increasing tendency to have practical points in treatment selected for discussion at meetings like this, for it is possible that some men may tell you what they will not write. Before I begin to deal systematically with the subject, I may say that the idea that little individual attention is paid to cases of recent insanity in asylums simply exists in the minds of those ignorant of asylum practice; I, for my part, believe that in few institutions for medical treatment is more constant and careful attention expended, and, so far as I can judge, we are much in the same position to mental conditions such as we are at present considering as we are to diseases like whooping-cough, influenza, scarlet fever, or a variety of other diseases that I could mention. We know that certain phenomena in the course of the disease are of malignant import, we recognise certain possible issues to each case, and we try by such means as are known to us to promote recovery and avert the tendencies to death or incomplete recovery.

I know that most asylum physicians hail the admission of an excited patient with pleasure, so soon as they eliminate general paralysis and epilepsy from the factors of the excitement. One feels that though as yet no specific which at once will allay the excitement and allow a return of the mental condition, which can produce coherent thoughts, words, and actions, is known to us, yet we know that judicious treatment can be of great use, and we know that such cases are the most hopeful that come under our care. But while we are pleased at seeing excitement present when we first get the patient, I think we all wish to get rid of it as soon as we can when the patient is under our care, provided that we do so in a way which will not prevent or retard recovery. I believe maniacal excitement can be quickly got rid of by means which in some cases retard and in others prevent recovery. In order to deal systematically with our subject, I propose to classify the forms of maniacal excitement in such a manner as, I trust, will not only meet with recognition but approval. I shall offer some remarks on the features of excitement, and the effects of its length of duration

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