Boston City Hospital.

CLINICAL MEETING OF THE STAFF,
DEC. 20, 1907.

A CASE OF MULTIPLE OPERATIONS FOR ABDOMINAL ADHESIONS.

BY F. B. LUND, M.D.

L. R., aged thirty-six, colored, had been operated upon in Philadelphia eleven years ago for uterine fibroids. Three years later she was operated upon at the Roosevelt Hospital in New York, for acute obstruction by bands, and again, soon after that, for chronic obstruction. Five years ago she was operated upon for a large ventral hernia by the writer, and soon afterward by Dr. J. C. Munro, for chronic obstruction, due to adhesions. Dr. Munro had some difficulty to find any free abdominal cavity to work in, owing to the extent and character of the adhesions, but finally was able to make a Murphy button anastomosis between the lower part of the ileum and the sigmoid. This operation relieved her so that she was able to go back to work. She enjoyed fair health and worked as a cook until recently, when she was sent to the hospital by Dr. Courtney, suffering from abdominal pain, distention and constipation. I operated upon a small ventral hernia in the right iliac region without relief. Her distention and discomfort continue, and further operation is proposed in a few days.

A few days later this was performed. The entire lower abdomen was found filled with intestines adherent to each other and to the abdominal wall, so that no real abdominal cavity could be gotten into until the incision was carried into the epigastrium along the border of the left rectus. Only about two feet of free intestine was found, starting from the beginning of the jejunum. With great pains and care, separating coil from coil and fold of mesentery from fold, about seven feet of the small intestine were freed. The loop of the sigmoid was found, but appeared to be obstructed at the pelvic brim, so that anastomosis with this, it was thought, would be unsatisfactory. The lower sigmoid and upper part of the rectum were so buried beneath the coils of small intestine, that it was impossible to free and bring them up. The finger introduced as high as possible per anum passed the valves and seemed to enter the lower sigmoid. At any rate, as far up as I could reach, the rectum was unobstructed, even somewhat dilated. The half of a Murphy button was carried up as far as possible into the rectum in a pair of long curved clamps, and by making the rectal wall prominent with this, it was possible to dissect the coils of small intestine away from above so as to come down upon it. The other half of the button was then introduced into the lowest coil of small intestine, which had been freed, about seven feet from the beginning of the jejunum, and the rectum was cut from above, so as to let the inner cylinder of the button project through it. Then by pushing down the upper half of the button, it was possible to effect an ileo-rectostomy in the bottom of the pelvis without sutures and with a minimum of soiling. It was recognized that by this procedure the entire large intestine was placed out of commission, and possibly hardly enough small intestine left to maintain nutrition, but it was necessary to get by the obstruction, and this was the only way to do it, except by an enterostomy, and the disadvantages of a permanent enterostomy of the ileum are too obvious to dwell upon. The abdomen was sewn without drainage. The wound was a long one along the outer border of the left rectus. The veins supplying the rectus were found and left intact.

The patient did well at first, and the distention was relieved, though she had three or four liquid movements a day, owing to the loss of the drying function of the large intestine. The button was passed in about two weeks. After about a month distention and vomiting appeared and rectal feeding had to be resorted to. This was tolerated for a short time only, and then small amounts by mouth were begun. Now (Feb. 15) there is no distention, the patient is being fed by mouth, and seems to be improving a little. The recent distention is undoubtedly due to the tying up by adhesions of the little bowel she has left. No further operation seems possible, and the question of her ultimate survival, with the limited amount of badly crippled intestine she has left, seems rather likely to be decided against her.

TWO CASES OF INTRALIGAMENTOUS FIBRO-MYOMA OF THE UTERUS, AND THE METHOD EMPLOYED TO CONTROL BLEEDING FROM THE BED OF THE TUMOR IN THE BROAD LIGAMENT.

BY C. M. GREEN, M.D.

CASE I. J. B., aged fifty, had had two children and three miscarriages. For three months she had had irregular, profuse uterine hemorrhage; and for two months obstinate constipation, obviously due to the pressure of a fibroid tumor which completely filled the pelvis. At operation a sessile growth, two to three inches in diameter, was found at the right cornu, the corpus uteri was of about normal size, but growing from the supravaginal cervix was an intraligamentous mass as large as a fetal head. The broad ligaments were laid open and the tumor removed with great difficulty. There was considerable oozing from separated adhesions. Some surgeons control bleeding in these cases by gauze pressure-drains, an opening being made into the vagina for removal, and the gauze covered in by closing the peritoneum. The reporter believes that a better way is to secure hemostasis, and at the same time to obliterate the cavity in the broad ligaments, by applying several tier sutures, and this method was followed in the two cases reported.

There was no post-operative hemorrhage in this case; but the patient died of shock and exhaustion on the second day.

CASE II. J. L., thirty-nine, single, had a large, multiple-fibroid uterus extending above the umbilicus, and the chief symptom was pain. There was a large, intraligamentous mass growing from below the peritoneum; this was enucleated, supravaginal amputation of the uterus was done, the broad-ligament cavity was obliterated by suture, and covered with peritoneum. This case has made an uninterrupted recovery, and will be discharged in a few days.

Dr. Green also showed an unmarried girl of eighteen, on whom he had operated, whose case was interesting from its rarity, — procidentia of the uterus in a nullipara. Two years previously, when sixteen years old, she had lifted a wash-boiler filled with clothes, and as a result, apparently, she suffered prolapsus uteri, so that the cervix protruded from the vulva. After unsuccessful treatment with pessaries in the Out-Patient Department, she entered the hospital, when the uterus was found retroverted and retroflexed, and it protruded from the vulva on straining. It was thought best to perform ventral suspension. At operation both ovaries were found cystic, and were resected. After the usual convalescence, examination shows, with the patient in the erect posture, that the uterus is in normal axis and position.

Referring to the subject of the conservative surgery of the ovaries and Fallopian tubes, Dr. Green reported a case from his service, on whom

he had operated in 1903 and 1904, and whose subsequent history he had recently learned:

R. F., aged twenty-nine, married six years, IV-para, entered the hospital Nov. 16, 1903, on account of backache and constant vaginal discharge. The uterus was retroverted, the right tube swollen, and the cervix torn. Curettage and bilateral trachelorrhaphy were performed, and the patient was discharged, apparently well, on Dec. 7.

Twelve days later, the patient returned, on account of pain in the left lower abdominal quadrant, and a diagnosis of salpingitis was made. At this time the husband acknowledged that he had gonorrhea. The abdomen was opened, and the left appendages were removed. The right tube, although swollen and congested, was pervious, and it was left *in situ*. The cystic right ovary was resected, the uterus was suspended, and the patient was discharged well, Jan. 31, 1904. It was thought at the time that the patient ran some risk of a second laparotomy by the conservative treatment of the right tube and ovary, and in view of the obvious Neisser infection.

The subsequent history of this patient is as follows:

She menstruated on March 18, 1904, and on Dec. 15 of the same year she gave birth to a full-term child, without any complication from the suspension of the uterus. Last June, eighteen months later, another child was born; and at the present time, although somewhat debilitated by lactation, the patient is entirely free from pelvic symptoms.

In this case conservative treatment of diseased appendages was successful; in some cases it is not. But is it not better occasionally to perform secondary laparotomies than to deprive young women of all hope of maternity, when even small portions of ovarian tissue may be left *in situ*, and when a tube, although not entirely healthy, may yet perform its function?

CANCER OF COLON.

BY FRANKLIN W. WHITE, M.D.

Male, aged thirty-six, good family history; operated upon for piles two years ago. For last eight months indigestion, occasional vomiting or regurgitation immediately after meals; epigastric distress occasionally relieved by food. In last month pain in right navel region; bowels loose of late. Best weight, 204; loss of 43 lb. in last few months.

Test of gastric secretion and motility show normal motility and secretion normal (free HCl, 43; total acid, 60) or increased (free HCl, 60; total acid, 98). The usual treatment for hyperacidity had relieved the symptoms somewhat.

I saw patient first on March 13, 1906; examination showed a large, vigorous man, slightly pale. A deep rounded solid mass, size of an apple, was found just above and to right of navel, slightly tender and movable, not felt bimanually in flank; liver, edge easily felt, not continuous with tumor. One examination of feces for blood on meat-free diet was negative. Diagnosis of probable cancer of bowel was made and patient referred to Dr. F. B. Lund, of Boston, for operation. At operation a cauliflower cancer was found encircling the ascending colon five inches above the cecum, with few secondary glands in the mesentery. The bowel and glands were resected and a side-to-side anastomosis made. Recovery was uneventful.

Patient had gained 40 lb. in the nine months since operation, has worked hard and steadily, had practically no digestive symptoms. He considers himself well.

The interesting features of this case are the brilliant immediate results of operation and the association of abdominal cancer with gastric hyperacidity. The unusual position of the tumor of the lower part of the ascending colon is explained by the adherence of the omentum to it, which dragged it upward and toward the median line. The single negative guaiac test of the feces for blood shows the need for repeated examinations in suspected cancer of the bowel. Curiously enough, positive results of the blood test are decidedly less constant and frequent in cancer of the bowel than in cancer of the stomach. Cases reported by Boas and Ewald confirm this observation, but no one has explained it.

GASTRIC ULCER.

BY FRANKLIN W. WHITE, M.D.

Male, aged forty-six. For two years he had had distress or pain two or three hours after meals; occasional vomiting; gradual loss of weight. In last three weeks there was much epigastric pain; frequent vomiting of small amounts of "coffee ground" material. Patient was pale, emaciated, very weak; had recent rapid loss of weight, 25 lb. in all. Hemoglobin, 65%; reds, 3,000,000. At first visit vomited a pint of typical "coffee ground" material, containing abundant free HCl.

Gastric contents after test meal, 150 cc., free HCl, 63; total acidity, 90; guaiac positive. Epigastrium diffusely tender; no tumor; 500-800 cc. of brownish fluid containing free HCl and digested blood were vomited on two occasions before breakfast.

The man's whole appearance, anemic, cachectic; the "coffee ground" vomiting, the gases and excess of fluid in the fasting stomach suggested cancer, and this diagnosis was made by two experienced physicians. The abundant reaction of HCl favored ulcer, or the early stage of a cancer developing upon an ulcer base (we know that this is the only form of cancer in which hyperacidity is likely to persist). This second diagnosis seemed to best explain the symptoms, the early distress, pain and vomiting at the height of digestion (ulcer), and the late, rapid loss of weight and strength, anemia and "coffee ground" vomit (secondary cancer). The treatment was rest in bed; exclusive rectal feeding first week; liquids and soft solids by mouth next four weeks; no meat extracts were given. The feces were examined frequently for blood by the guaiac test, with the following results:

Nov. 20, positive,	Dec. 8, negative,
Nov. 26, positive,	Dec. 12, negative,
Nov. 28, positive,	Dec. 13, positive,
Nov. 29, positive,	Dec. 15, negative,
Nov. 30, negative,	Dec. 17, negative,
Dec. 1, positive,	Dec. 19, negative,
Dec. 3, positive,	Dec. 23, negative and
	negative thereafter.

The intermittent appearance of the blood in the feces was very strong evidence in favor of ulcer and against cancer. The diagnosis of simple ulcer was finally made and justified by the consequent history.

The patient gained 20 lb. in the next few months; has worked steadily during the past year and felt perfectly well, except for brief attacks of hyperacidity, which are promptly relieved by appropriate diet, olive oil and alkalis.

The especially interesting features in this case were the valuable aids in diagnosis, given by the

guaiac test of the feces for blood and the good immediate (one year) result of medical treatment.

The presence of a large amount of fluid in the fasting stomach was not due to organic pyloric stenosis, but evidently to hypersecretion, or possibly to stasis of fluid from pyloric spasm.

Reports of Societies.

AMERICAN GYNECOLOGICAL SOCIETY.

THIRTY-SECOND ANNUAL MEETING, HELD AT WASHINGTON, D. C., MAY 7, 8, AND 9, 1907, IN CONJUNCTION WITH THE CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.

The President, DR. CLEMENT CLEVELAND, New York, in the Chair.

METASTATIC CARCINOMA OF THE TUBE AND OVARY IN CANCER OF THE CERVIX UTERI.

DR. FRED J. TAUSSIG, of St. Louis, Mo., read a paper on this subject, in which he concluded that mild chronic inflammatory conditions of the tube and ovary were frequently met with in cancer of the cervix. Whether this was merely a coincidence or not, he would be unwilling to say. On the other hand, cancerous metastases in these organs were extremely rare in cervical cancer. In fact, he could find no record of such metastasis in an operable case. In carcinoma of the body, however, they were not infrequently seen in tube or ovary, or both. Hence it would seem logical to advise the removal of both tubes and ovaries in every case of cancer of the body. If, however, the patient was still five or ten years from the time of the menopause, and the site of the cancer be in the cervix, the saving of one ovary would be attended with practically no risk to the patient and might relieve her of the disagreeable symptoms of the premature menopause. Since this could be done without interfering with the complete removal of the lymphatics directly tributary to the cervix he believed it logical to leave one ovary, or a portion of one ovary, in every operation for cervical cancer in a woman under forty years of age.

DISCUSSION.

DR. J. WESLEY BOVEE, of Washington, D. C., said metastases in cancer of the uterus were by no means common, and that as the disease spread metastases occurred. This emphasized the fact that in the cases brought to the attention of the gynecologist he was helpless in the treatment of cancer of the uterus; that in the cases in which the conditions would ordinarily offer great hope of success we would find that metastases occurred in those structures which we would not remove, the result being that cancer recurred or continued unsuspected. At best, the treatment of cancer of the uterus was not hopeful, notwithstanding the claims of radiographers and the demonstrators of radium, etc., and those who did the most radical surgical operations. He was not prepared, in the present light of surgery of cancer of the uterus, to accept the suggestion of the essayist, that it was safe to leave a portion of an ovary or even one ovary in extirpating cancer of the uterus. His own conviction was that the operation should be as radical as it could be consistent with saving the life of the patient.

DR. LAPHORN SMITH, of Montreal, reported a case of cancer of the cervix in which operation was done early by another surgeon, with every possibility of a complete recovery of the patient and freedom from

recurrence; yet this woman came to him a year later, with no sign of recurrence in the vagina, but with two distinct masses in the ovaries which could be readily felt. He considered it too late to do anything in an operative way. This case made such an impression on him that ever since, when doing vaginal hysterectomy, he always removed the tubes and ovaries. He did not think it was safe to leave an ovary or a piece of an ovary, when there was such a tremendous risk of recurrence.

DR. REUBEN PETERSON, of Ann Arbor, Mich., desired to place himself on record as voicing the sentiment of Dr. Bovee against the leaving of one ovary, or part of an ovary, in the operation for cancer of the uterus. This was a step backwards, and was not in accordance with progress that had been made in the last ten years in the treatment of cancer of the uterus. He was not convinced that the leaving in of one ovary after the removal of the uterus helped the patient, so far as the menopausal changes were concerned. He had been unable to see much, if any, difference where an ovary had been left in and where it had been removed, after the removal of the uterus for cancer.

DR. WALTER M. CHIPMAN, of Montreal, doubted whether it was a wise thing to leave even one ovary, or even a part of one, after the removal of the uterus for cancer, no matter where the cancer was situated. While it was true that the ovary was not in the direct path of the lymphatic distribution of the pelvis, yet so great and so rich was the anastomosis that he thought the leaving of ovaries must always be a risky procedure.

DR. TAUSSIG, in closing the discussion, said he anticipated that most men would hardly agree with him as to the advisability of leaving a portion of an ovary in the class of cases under discussion; but he believed, however, from the statistics that the procedure was not at all unsafe, and it seemed to him that it was just as logical to advise the removal of the appendix as to advise the removal of the other ovary. The appendix was a useless organ; the ovary — at least in the opinion of some — helped to make the menopausal disturbances less severe in women under forty years of age, if left.

A NEW METHOD OF VERSION.

DR. A. F. A. KING, of Washington, D. C., spoke of the correction of transverse presentations by the hitherto unrecognized factor of thigh-pressure upon the abdomen, induced either (1) by posture, or (2) by manipulating the lower limbs. The former, he said, was Nature's method of preventing and correcting cross-presentations; and in primitive races was daily exercised by the squatting posture during defecation, etc. Squatting was not a symmetrical proceeding; the two thighs did not press equally. One foot was flat upon the ground and in advance; the other, in the rear, rested only on its toes. The thigh of the front foot would press high up upon the breech end of the fetus; the thigh of the rear foot would press low down upon the head forcing it from the iliac fossa into the pelvic brim, as was illustrated by diagrams.

THE SUPERIORITY OF PRIMARY OVER SECONDARY CÆSAREAN SECTION; FEASIBILITY AND ADVANTAGES OF A PREDETERMINATION OF THE METHOD OF DELIVERY.

DR. EDWARD REYNOLDS, of Boston, spoke of primary operations being determined upon in advance of labor and performed at an elected date, or with the advent of the first pains. Secondary operations may be performed as soon as a test in labor had shown that the natural powers were likely to fail and before serious exhaustion set in. Late operations were considered in