OVARIAN TUMOUR OBSTRUCTING DELIVERY.

POSTERIOR VAGINAL SECTION AND OVARIOTOMY DURING LABOUR—
OPERATION AND DELIVERY AT ONE SITTING—RECOVERY.*

By JOHN W. TAYLOR, F.R.C.S. ENG.,

Professor of Gynæcology, Birmingham University; Surgeon to the Birmingham
and Midland Hospital for Women.

ABOUT 2 a.m. on Sunday, September 29, 1901, the following note was brought to me from Dr. Bernays and Dr. Whitehouse of Solihull :

‘ We have a very awkward confinement case—some sort of tumour in Douglas’s pouch. We cannot move it, and the head is above the brim, pushed forward, and to the right. We have given an anæsthetic and failed to push the tumour away, and forceps and turning alike seem difficult and doubtful. Will you come out with the husband, prepared to operate if needful ?

‘ The “ waters ” broke at 8.30 p.m., and the pains are strong. The patient is about thirty, and this is her second pregnancy.’

I arrived about 4 a.m., after a long drive of 9 or 10 miles, and found, as Dr. Bernays had told me, that the patient, a strong young woman of thirty years of age, who had been married three years, and had one child two years ago, was now in violent labour at full term with her second child, but with a large cystic tumour blocking the pelvis behind the cervix, and obstructing the passage of the head.

On abdominal examination the whole of the abdomen appeared to be filled with the tumour of the pregnancy, which was not displaced laterally in any way, so that the obstructing tumour was evidently directly behind the distended uterus and filling the pelvis.

There was no real malposition of the fœtus, the head being ready to engage the brim as soon as the way was clear.

The room was made ready for operation, while I considered for a time what I should do.

Immediate operative action was undoubtedly imperative, but it was not easy to at once decide whether abdominal or vaginal section would prove the better method of removing the tumour.

If I adopted abdominal section I should evidently have to make a large incision, and probably to eviscerate the pregnant uterus or do a Cæsarean section, before I could get at the imprisoned tumour.

If I adopted vaginal section I should have an awkward field for

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operation, both vulva and vagina being converted, through prolonged pressure from above, into a soft cushion of dilated veins; the wound would be in a dangerous and septic situation for the subsequent delivery, but, on the other hand, I should come directly upon the tumour, and be very likely able to remove it without an abdominal incision and without incising the uterus.

I decided to operate by the vaginal route.

Getting what lamps and candles the house could afford, so as to have a good light behind my head, and with aseptic instruments arranged on my right hand, I had the patient anæsthetized by Dr. Bernays, removed from her bed to a low table, and placed in the lithotomy position immediately in front of my operating chair. Dr. Whitehouse and one of my own nurses ably assisted me.

It was shortly after 6 a.m., and there were faint indications of dawn as I began to operate. The vulva and vagina were carefully disinfected, and then a large incision was made behind the cervix into Douglas's pouch. This caused a tremendous gush of venous hæmorrhage, but the cyst wall was immediately seen, and almost as quickly seized and tapped. As some two or more pints of fluid from the ovarian cyst came away the hæmorrhage lessened, and in a very short time this ceased to be any longer alarming. The collapsed cyst was then drawn down into the vagina, and the pedicle felt high upon the left side of the enlarged uterus, but almost beyond reach of the fingers. This was seized with forceps, and after gentle traction on the tumour a stout ligature was passed over the blades, and tied tightly on the uterine side of the forceps.

The tumour was cut off and the forceps removed. The only hæmorrhage still came from the incision. The pouch of Douglas was well cleaned and the wound plugged by a sterilized pad, but the ends of the ligature were not (at this stage) cut short.

The next important question was that of delivery of the patient. She was under anæsthesia, the cervix was soft and very dilatable, and after the prolonged anxiety and trouble of the night it appeared wiser to get the labour over, if possible, before the patient had recovered consciousness.

Accordingly, I delivered the child by forceps. This was done without any injury to the cervix. The placenta followed by expression, and pressure was maintained over the contracted uterus by Dr. Whitehouse, while I returned to the original field of operation. The cervix was held up by volsella and the parts well cleaned. The pad plugging the posterior incision was then removed, and the ends of the pedicle ligature cut short. This was perhaps the most difficult

part of the operation. I had expected that when the uterus was emptied the ovarian pedicle would become much more accessible and, possibly, visible as well as tangible. I did not find it so, and had to cut the ends of my ligature short, by the sense of touch alone, within the pelvis. Happily, there was no bleeding from within the pelvis, and that of the vaginal wound was easily controlled by passing one suture at each end of the incision.

The rest of the incision was filled with an iodoform gauze drain, which passed into the pelvis at the back of the uterus.

The volsella was removed from the cervix, the vagina and vulva made perfectly clean, a tight binder applied to the abdomen, and the patient removed to her bed with a hot-water bottle to her feet.

Dr. Bernays and Dr. Whitehouse conducted the after-treatment of the case, which was uneventful. The bowels were moved on the following day, and the patient made a good recovery.

The baby also did well.