

THE  
TREATMENT OF OBSTRUCTED LABOUR  
WHEN CAUSED BY THE IMPACTION  
OF A TUMOUR IN THE PELVIS,  
ILLUSTRATED BY FOUR  
CASES.

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THE subject of this communication claims the attention of the greater number of our profession. Every general practitioner, every physician, and every operating surgeon may be called upon in such cases to give distinct advice and to carry out prompt treatment without any previous warning. Delay or want of decision on the part of the practitioner may be followed by the most disastrous consequences. My object in bringing this subject forward is to advocate in all these cases abdominal section and removal of the tumour by the method described hereafter, which was carried out in Case 4. The various arguments for such treatment will be best shown by deductions drawn from the histories of the cases which I am about to relate.

It will be observed that the condition is not limited to the primipara but that a multipara who has been easily delivered on previous occasions may without any symptoms during pregnancy be found in labour with the pelvis occupied by a tumour to such an extent that delivery is impossible, from one to two years apparently being long enough for the growth of a dermoid ovarian cyst of sufficient size to fill completely the pelvis. The tumour can occasionally be pushed up into the abdomen and when this can be done without using too much force it relieves the case of all urgency for the time being, the necessity for abdominal section being only deferred. It is evident that if labour is at all advanced this simple procedure is impossible; equally so it is if the tumour has contracted adhesions in the pelvis. Rough treatment of any kind is liable to be followed by sloughing or suppuration of the tumour and thus to place the patient in great danger. The temptation to apply forceps might be yielded to in cases in which the pelvis was only partly obstructed. The danger of such practice is well exemplified in the after-history of Case 3, in which the ruptured and suppurating cyst had to be removed when the patient was almost *in extremis*. Should any special complications of labour arise, as, e.g., those in Case 2, it may be necessary to empty the uterus as rapidly as possible in addition to removing the obstruction. The only remaining way out of the difficulty may be, as in Case 2, by Porro's operation, which is a severe form of mutilation, but can be more rapidly performed than Cæsarean section, and hence may be called for when the patient's condition is such as not to be able to stand any prolonged manipulation. Operations through the vagina I will only mention to reject, as I consider an opening into the peritoneal cavity from the vagina at any time to be a dangerous thing, and especially is it so at the time of labour, and if made during pregnancy before labour commences the hæmorrhage and necessary traction on the perineum would most likely induce labour.

All the foregoing points have occurred to me in actual practice; the result of my experience is to make me advocate the treatment which was carried out in Case 4 as the recognised treatment for the future whenever it is possible—viz., to open the abdomen as soon as the diagnosis is made—preferably before labour sets in—to turn out the pregnant uterus, to remove from behind it the tumour which occupies the pelvis, then to replace the uterus and sew up the wound. If labour follows immediately no harm need result; if as in Case 4 the wound has time to become soundly healed before labour sets in, still better is the prospect. Cæsarean section or some form of hysterectomy would be reserved for those cases in which after opening the abdomen it was found either that the tumour could not be removed or that it was too intimately attached to the uterus to be removed and at the same time to allow the uterus to remain without increased risk. The cases shortly are as follows.

CASE 1.—On Dec. 23rd, 1888, a primipara, aged 22 years, was in the commencement of labour. The pelvis was

occupied by a semi-solid tumour, so that there was only just sufficient room for one finger to pass close behind the pubes to reach the os. Having failed to push up the tumour I proposed to the late Mr. W. Cadge, who saw her with me, to open the abdomen, to draw the uterus out of the wound, to remove the tumour from the pelvis, and then to replace the uterus and to deliver naturally. This proceeding he, however, did not sanction as he did not think it possible; accordingly, with a very great amount of force, I pushed the tumour up into the abdomen. Normal labour followed and the patient did well. A second pregnancy followed and when labour occurred I again pushed up the tumour as before and no bad symptom followed.

CASE 2.—In March, 1892, a multipara whom I had attended less than two years previously in a labour which presented no complication was again in labour at full time. There was accidental hæmorrhage, with tonic contraction of the uterus of nine hours' standing, together with a semi-solid tumour which exactly filled the whole pelvis and appeared to be firmly fixed there; her condition was one of such great exhaustion that the quickest possible method of delivery was the only justifiable proceeding, hence Porro's operation was the one chosen and at the same time the tumour, a dermoid ovarian cyst, was removed from the pelvis; the patient recovered. This case has been already published.<sup>1</sup>

CASE 3.—In February, 1895, a mother of seven children was again in labour at full time. The pelvis was partly occupied by a semi-solid tumour. Delivery was accomplished with the forceps. Gradually urgent symptoms commenced and increased. The patient had pelvic peritonitis, the upper part of the abdomen being excluded by adhesions. There was high temperature with feeble and rapid pulse and when I opened the abdomen I found the pelvis containing a mixture of pus, sebaceous material, hair, bone, teeth, and the ruptured cyst, all of which were washed out as rapidly as possible, and finally after a tedious after-treatment the patient quite recovered.

CASE 4.—This patient was fortunate in having a sharp attack of diarrhœa and pain which called attention to her condition and led to the discovery of the tumour during the eighth month of pregnancy by Mr. C. E. Muriel who attended her. The patient was a multipara, aged 30 years. Her last labour, which was quite natural, had occurred rather less than two years previously. On examination the whole of Douglas's pouch was filled with a semi-solid mass, leaving just room for the finger to pass close behind the pubes to the os uteri, which could with some difficulty be reached. The tumour appeared to be firmly fixed and examination per rectum showed that it was not attached to the sacrum. I decided to remove the tumour by abdominal section and hoped to be able to do this and to get the wound soundly healed before labour commenced.

On Nov. 6th, 1895, at the end of the eighth month of gestation, I made an incision in the middle line 11 inches long and drew out the whole fundus of the uterus, which, with the able assistance of the late Mr. W. Waring, was kept wrapped in hot sponge cloths; then, by passing my hand in behind the uterus I succeeded in enucleating the tumour from its adhesions in the pelvis. It was the right ovary and was just large enough to fill completely the pelvis. Its pedicle was twisted upon itself, one whole turn from left to right. This was ligatured and the tumour was cut away. The uterus, which had been outside the abdomen for a space of five minutes, was now with some difficulty returned. This was no easy task as there appeared to be insufficient skin to cover it. However, by dragging upwards the two sides of the abdominal wound it was eventually made to close, a large number of sutures being used. The whole operation lasted 25 minutes.

On opening the tumour it proved to be a suppurating dermoid cyst. Its walls were becoming gangrenous and I have no doubt but that it would have burst during labour. The after-history contains no complications, the wound healed quickly and soundly, and the patient was able to be moved to her own house in three weeks. On Dec. 1st, that is, 25 days after the operation, she was delivered by Mr. Muriel with the forceps in order not to allow more strain to be put on the cicatrix than was possible. The child was full-sized and the mother made an uneventful recovery.

I have not at present seen any record of a similar operation but I hope that after this it may hold a recognised place in surgery as the best treatment for these cases.

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<sup>1</sup> Brit. Med. Jour., Feb. 11th, 1893.