

III.

Two Cases of Para-Vaginal Section for Uterine Fibromyoma.*

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THE uses of Schuchardt's para-vaginal section have been ably extolled in this country by Sir W. J. Sinclair, both in a paper published last year in the *Journal of Obstetrics*,¹ and also in his remarks introductory to a discussion on the subject which took place at a meeting of the North of England Obstetrical and Gynæcological Society held at Manchester on the 15th of December, 1905. During that discussion, some members expressed the opinion that this method of enlarging the vaginal aperture is unnecessary, and that it largely increases the risk to the patient by causing extra loss of blood and prolonging the operation. It was also pointed out that when the method is employed in operating for cancer, early recurrence in the scar of the para-vaginal incision is the rule. Of the advantages or disadvantages of the incision in vaginal hysterectomy for cancer I have no personal experience, as, in cases of carcinoma in patients with small vaginae, I have hitherto operated by the abdominal route. Recently, however, I have twice had occasion to operate on elderly virgins for fibromyoma under circumstances which I considered to render the abdominal route out of the question. In these cases the para-vaginal incision rendered vaginal operation possible, in spite of extreme narrowness of the vagina. It did not cause undue hæmorrhage, nor did it much prolong the operation. Owing to the circumstances of one case, the para-vaginal incision was not closed by any suture, yet it healed up without any permanent injury to the pelvic floor. I therefore wish to advocate the use of this incision in certain cases, as the best and by no means a bad way out of difficulties which may any day be encountered.

It may be suggested that in these two cases sufficient room could have been gained by dividing the perineum, as has been done occasionally for many years past. In women, however, who have short perineal bodies, central incision gives very little access. Had I

* Read at a meeting of the North of England Obstetrical and Gynæcological Society, held at Sheffield, November 15th, 1907.

1. *Journal of Obstetrics and Gynæcology of the British Empire*, 1906, vol. ix., p. 241.

begun in these cases by making central perineal incisions, they would certainly have been extended by tearing into the rectum. Indeed, one could have split the pelvic floor back to the very tip of the coccyx without gaining more free access than that given by the para-vaginal incision.

CASE I. Miss C., aged 38, suffered from severe uterine hæmorrhage, anorexia and profound anæmia. Menstruation began at the age of 14. It was formerly regular, of the 28 days' type, 4 days in duration and moderate in quantity. Six years ago there was an increase in the length of the periods and in the quantity of the discharge. Four years ago the patient was operated on by Dr. J. W. Stenhouse for empyema and, under anæsthesia, the uterus was then found to be much enlarged. Menstruation continued to be prolonged and excessive, until in March, 1907, serious flooding occurred. This recurred in May. In June, after fainting repeatedly through loss of blood, the patient became unable to retain food, and vomited after all forms of nourishment. On July 1st she travelled to Manchester to see Dr. Stenhouse, and fainted on the doorstep of her lodgings on arrival.

On July 2nd Dr. Stenhouse and I saw her together. She was extremely anæmic, with a rapid faint pulse and rapid breathing. Her appearance suggested prolonged poisoning by the absorption of decomposition products, and she apparently had not long to live.

Abdominal examination showed that the uterus was enlarged and ovoid in form, the fundus reaching the level of the umbilicus and being very hard and firm.

The clothes, bed and person were stained with dark, offensive blood, which continued to escape in considerable quantity.

The vaginal orifice was very small, the firm, rigid perineum preventing the insertion of more than one finger.

The vaginal cavity was itself small, and was filled by the lower pole of an ovoid fibromyoma, which had the size and shape of an ostrich's egg. The cervix uteri was dilated to the size of a crown piece, and had a thin, very rigid margin, which was stretched over the lower pole of the fibroid.

We were now in grave doubt as to the proper course to take. We decided that immediate operation would expose the patient to less risk than would any attempt to nurse her into better condition. The patient, therefore, having been anæsthetised by my colleague, was placed in the lithotomy position, and supported by a Clover's crutch. I then, with a District Nurse as my only assistant, cut into the ischio-rectal fossa on the left side, divided the whole left lateral vaginal wall, and continued the skin incision to a point one inch behind and an inch and a half to the left of the anus. The patient was so blood-

less that there was hardly any hæmorrhage. This free incision gave only just enough room in which to work. The fibroid was then removed bit by bit, and it appeared that its attachment occupied the fundus of the uterus and its right wall down to an inch and a half from the os externum. When about half the fibroid had been removed, though very little blood had been lost, the patient became collapsed. Artificial respiration had to be carried on for some time. Hot saline solution was thrown into the rectum and strychnine was administered hypodermically. Brandy was given by the rectum and later by the mouth.

When breathing recommenced the remaining half of the tumour was rapidly removed, the uterus then being practically inverted by the traction which had been kept up on the mass to prevent blood loss during the interruption. The uterus, vagina and para-vaginal incision were packed with gauze. The patient was then hurried into bed and surrounded with ordinary quart bottles filled with hot water. It was clearly undesirable to stitch up the paravaginal wound, especially having regard to the need for free drainage, the whole field having been contaminated by fæces in the emergency. On July 3rd the patient had a pulse of 60, took fluids freely, and expressed herself as comfortable. The gauze was all removed and douching was begun. There was some considerable disturbance of temperature during the first week, owing to absorption from the bed of the tumour and from the para-vaginal wound. The motions were offensive for several days, and numerous enemata were required. There was no vaginal or uterine discharge after the first ten days. After four weeks the para-vaginal wound had quite healed and the scar was hardly more conspicuous than in many cases in which sutures have been used. The integrity of the pelvic floor was in no way impaired. The vaginal orifice just admitted two fingers. The cervix uteri was closed but remained large and hard. The uterus was rather large, and firm in consistence. It was somewhat fixed, especially on the left side. There was no difficulty in micturition or defæcation throughout; in fact, the patient complained of nothing after the date of operation. She went away for a holiday five weeks later, and is now in perfect health. Menstruation has not returned.

CASE II. Miss G., aged 44, complained of severe and prolonged bleeding from the womb, with consequent impairment of health.

Menstruation began at the age of 14 and was painless and regular, and moderate in quantity and duration.

About three years ago she began to suffer from excessive bleeding and was treated for a displacement of the womb with some success. A year later the bleeding returned, and Dr. J. W. Stenhouse removed, by avulsion, a large submucous fibromyoma, which had become

pedunculated, and was being expelled through the dilated cervix. There was no further bleeding for two years. Early in July, 1907, the hæmorrhage began again. It was accompanied by pain, and was continuous up to the time when Dr. Stenhouse and I saw her together on September 20th. The uterus was found to be enlarged to the size of a fist, and was irregular in form. The cervix was dilated, and the os externum was stretched over the lower pole of a submucous fibromyoma about equal in size to a bantam's egg. The vagina was very small. The perineum was very rigid, and the distance between the vagina and the anus was very short. The patient had already submitted to the removal of one fibroid polypus, and wished to be freed from the possibility of further trouble from this source. The shape and size of the uterus indicated the presence of several fibromyomata. Therefore, taking into consideration the age of the patient, we decided to undertake a hysterectomy rather than merely remove the large polypus which was then presenting at the os uteri.

The para-vaginal incision was made as in Case i. The cervix, distended by the polypus, was found to be inconveniently large. The bladder was therefore pushed off the uterus, the anterior uterine wall was split, and the polypus was removed by cutting through its attachment to the posterior wall of the fundus. The uterus was then removed in the usual way, and the stumps of the broad ligaments were drawn down and stitched into the vaginal vault.

The gap which had been cut in the margin of the pelvic diaphragm was closed by drawing together with catgut the divided portions of the levator ani and its fascial sheath.

The incision in the left vaginal wall was closed with a continuous suture of catgut, hardened with chromic acid. The skin incision was sutured with silkworm gut, a gauze drain being left in its lower angle for 24 hours. Recovery was smooth and the para-vaginal wound healed by first intention.