NOTES AND REMARKS ON A CASE OF HYSTEROMYOMECTOMY.

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In these advanced days of abdominal and pelvic surgery, when such a case as that which I now submit to you is no longer the rarity it would have been in Dublin some four or five years ago, I feel that I should almost apologise for bringing it in the form of a paper before the members of this Section were it not that the recounting of my errors and difficulties might be of service to some of the junior members if they had to deal with such a case, and that I hope the details may evoke valuable criticism and advice from the senior members who have had opportunities of dealing with similar cases.

The previous history of the case is as follows:—

Last May I was requested to see the patient, who at the time was suffering from a gastric and bilious attack. I made the following notes:—"Unmarried, age thirty-two, rather under average height, complexion florid, general health fairly good, suffers occasionally from constipation and bilious attacks—often dyspeptic; menses, until four months ago, were regular at monthly intervals, painless, lasting three days; some premenstrual leucorrhœa for two days. Since January menses have come at intervals of five weeks, lasting five to seven days, more profuse and accompanied by pain, both in the lower part of abdomen and at sides. On external palpation a tumour was discovered extending from the pubis to umbilicus—semi-elastic, movable; when patient lies on her back

it seems to encroach more on the right side than on the left; slight tenderness at upper and right side of tumour. Patient denied the knowledge of the existence of this tumour until her attention was drawn to it on this occasion. Stethoscope revealed no murmur. Measurements as follows:—From symphysis to upper border of tumour, 21·5 cms., or 8½ in.; circumference at umbilicus, 71 cms., or 28 in.; from umbilicus to right ant. super. spine of ilium, 15·25 cms., or 6 in.; from umbilicus to left ant. super. spine of ilium, 14 cm., or 5½ in. Very little information could be gained by a vaginal examination, the hymen being intact; the introitus vaginæ was very small; the abdominal walls were very tense, and the patient, moreover, was very nervous. The cervix, which was well formed, was a little lower than usual in vagina, and sound passed 2¾ inches. Uterus could be raised by pressing on cervix, but seemed to raise tumour with it. Tumour gives feeling of elasticity; no fluctuation; clear intestinal percussion note to either side of tumour. Tumour was not rotated, while sound was in uterus on this occasion. She complained of more discomfort and pain on the right side than on the left.

The diagnosis seemed to lie between a multilocular ovarian tumour, with uterine adhesions, and a uterine myoma; to the latter view I inclined at that time.

Subsequently, in Sept., Dr. G. H. Kidd kindly saw her with me. On this occasion, although less nervous than formerly, it was extremely difficult to make a satisfactory examination. The sound passed 2¾ inches, and the handle of the sound, when the tumour was rotated, only seemed to move as much as if the motion was communicated and not direct. Dr. Kidd inclined to the belief that the tumour was ovarian, and on this occasion I agreed with him. Since the occasion of the first examination the menses had occurred at even longer intervals, were more profuse and accompanied by more pain.

The tumour had visibly and sensibly increased in size, her dresses no longer fitting her; it had given her much discomfort, irritating the bladder and causing frequency of micturition; it also, from its weight, interfered with her walking much. She said she was "never comfortable." The measurements had increased, that from the pubis to the upper border of the tumour from 21·5 cms. to 25·5, and the circumference at the umbilicus from 71 cms. to 76 cms. Tumour continued to trouble her more on the right side. Believing it to be ovarian, she was advised to have it removed, and to this she consented. The operation was performed on the 29th September, Dr. Wm. Smyly kindly assisting, while Dr. Harley gave ether. Dr. G. H. Kidd was unfortunately, at the last moment, prevented from attending. The patient had been prepared in the usual method. The bowels were thoroughly cleared out, the symphysis pubis, always a favourable nidus for bacteria, had been shaved, patient had a hot bath the preceding evening, and a wet pack of carbolic solution placed over the abdomen for the night; heart and urine were examined and found normal. All the preparations were carried out with aseptic precautions. When the incision had been made and the peritoneum opened, there was no ascitic fluid. The tumour did not present the usual smooth pearly appearance of an ovarian cyst, and on enlarging the incision so that the surface of the tumour could be followed down into the pelvis, it was found that the body of the uterus was incorporated with the tumour. Acting on Dr. Smyly's advice I proceeded to remove the tumour and uterus. Having come unprovided with a transfixion pin and serre-nœud, Dr. Smyly sent for them to the Rotunda, knowing that they would be aseptic. In the meantime the incision was carried downwards, as far as possible with regard to the safety of the bladder; it was also continued upwards to the left side of the umbilicus for a distance of two inches, which

had to be still further increased before the tumour could, after repeated efforts, be turned out through the wound; there was, up to this point, little or no hæmorrhage. The right broad ligament was the first to be ligatured and separated; it was tied in three portions. During this procedure a large vein bled profusely, whether injured by the pedicle needle in passing one of the ligatures, or by the tension caused by drawing forward the tumour, or by both causes together I know not, but it was quickly secured. The left broad ligament was then treated in a similar manner. The elastic ligature was applied so as to clear the tumour, and the delta metal transfixion pin was introduced. The tumour was then cut off, leaving a stump which was formed by the lower portion of the uterus, the cavity of which had been cut through. A great deal of blood drained from the tumour as it was being removed, but the elastic ligature completely controlled any hæmorrhage from the stump. The cavity of the uterus in the stump was freely cauterised with Paquelin's cautery, the surface of the stump being also touched over, so as to assist in keeping the surface of the stump as dry as possible. The peritoneal cavity was then carefully cleansed of all clots, &c., and the wound closed. The first sutures inserted—namely, those immediately above and below the stump—were made to catch up the peritoneum on the stump with the tissues and peritoneum on each side so as to occlude or seal off the peritoneal cavity above and below from any possible contamination from offensive discharge. There were nine deep sutures and six superficial—silk being used which had been previously boiled in carbolic solution and then kept in absolute alcohol. The length of the incision, when the sutures were all in, was 16·5 cms., or 6½ inches. It had been intended to use Kœberle's serre-nœud, but portion of it had been dropped in transmission from the Rotunda, so the elastic ligature was left. The stump was dressed by slipping

all round it strips of iodoform gauze; it was then powdered with a preparation composed of three parts of tannic acid to one part of salicylic acid, which had the double advantage of being antiseptic and of drying the stump. No drainage-tube was used; the abdominal incision was powdered with boracic acid and covered with iodoform gauze. The abdominal walls were supported with strips of adhesive plaster, a good pad of alembroth wool being placed over all, under a binder. As regards the extra-peritoneal treatment of the stump, I may here mention, quoting from a paper of Dr. Bantock's, on Fibroid Tumours, that Dr. Martin, of Berlin, who had a very extended experience of the intra-peritoneal, has abandoned this operation for that of complete extirpation of the uterus.

Although the operation took considerably more than two hours to perform, there was no collapse, the temperature at 7 p.m. being 98° and the pulse 76. It is unusual not to have collapse after a prolonged operation of this nature, and I attribute its absence to the great care which was taken to keep the intestines warm with hot sponges and to expose them as little as possible. The patient was not given anything except an occasional teaspoonful of cold water until 12 o'clock the next day, when she got ʒi Denaeyer's meat peptones; this, with whey, peptonised milk, and Caffyn's Liquor Carnis formed her diet for three days, when she got bread and milk, fish, &c. The catheter was passed every six or eight hours for the first week, after which she passed water herself. I do not believe that catheterisation is productive of as much harm as some authorities think, if proper precautions are used to ensure the instrument being perfectly aseptic; and for this reason I think the glass catheter with females is the safest to use. Constipation was one of the troubles during convalescence, and had to be regulated by such means as calomel, magnes. sulphat., colocynth and hyoscyam.,

Operation, Hysteromyomectomy.

MONTH & DATE	SEP. 29	30	OCT. 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	NOV. 1	2	3
DAY OF DISEASE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
Time of Observation	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E

Hyperpyrexia

Pyrexia

RED LINE INDICATES PULSE

BLACK LINE INDICATES TEMPERATURE

Normal

Subnormal

TEMPERATURE FAHRENHEIT SCALE

106°	
105°	
120 104°	
110 103°	
100 102°	
90 101°	
80 100°	
70 99°	
60 98°	
97°	
96°	

C

41°	
40°	
39°	
38°	
37°	
36°	

cascara sagrada, and enemata. Indeed at one time there was so much trouble in getting the bowels to act that I feared some band of organised lymph might, by constricting the bowel, be the cause; but I am glad to say these symptoms gradually disappeared. She was troubled with flatulence and once or twice with vomiting, but this seemed to depend more on the weak state of her stomach than on anything connected with the operation. The wound was not dressed for a week, the abdominal incision was found completely united. There was some discharge about the stump, which subsequently was dressed every second day until the eighteenth day, when the pin and stump came away, leaving a granulating cavity with a small yellowish-looking slough. This sinus was dressed and syringed every day, and the slough came away with elastic ligature four or five days later; sinus did not close until two of the abdominal ligatures of strong silk were discharged, at an interval of eight days between them. She was supplied with an abdominal belt and pad and left the private hospital on the 17th November. She took a month's holiday in the country, and has continued quite well ever since. The temperature never rose above 100°, as will be seen by referring to the accompanying chart, while for three weeks or more the temperature remained subnormal, sometimes registering as low as 96·8°. This temperature was verified by having it taken in the mouth and by different thermometers. This period was synchronous with the time during which the abdominal sinus remained open and before the last ligature was discharged.

This clinical record of temperature seems very interesting to me, and it certainly seems to depend on the presence of suppuration caused by these ligatures that came away and kept the sinus open, as the temperature rose to normal when they were discharged and the sinus healed. There was no pain or inflammation at the seat of this suppuration, nor

during this period was the patient at all depressed; she was cheerful, and ate and slept well—in fact was up and walking about. While the temperature was so low the patient was given stimulants and had hot water bottles in her bed. I would wish to have the opinion of some of the senior members of this Section as to the causation of reduced temperature in the presence of suppuration. I think it is a point on which too little stress has been laid in the reporting of cases.

On looking at the specimen here shown, the upper portion of the cavity of the uterus can be seen, the cavity in this portion only measuring about $1\frac{1}{2}$ inches in depth, so that there could have been no error in the original measurement of the cavity. It seems somewhat unusual that the cavity of the uterus should be so little enlarged considering the size of the myomata growing in connection with it. The section through the tumour shows that it is mainly composed of two large myomata that have amalgamated, and which cause a dip in the surface which might have been misleading, and simulated the feeling of a multilocular cyst. The tumour seemed much more elastic when recent, and, of course, contained a great deal of blood. When its presence was first discovered, the patient, in answer to inquiries, persisted in stating that she was never previously aware of its existence, and on more than one occasion since, reiterated this statement, although at the time the tumour was fully the size of a fœtal head at full term. This point is worthy of attention as it seems strange how a well-educated woman, observant in other matters, could overlook such an obviously important physical change. Yet such cases are well known amongst women whose veracity is unimpeachable, and who could not possibly have any object in practising deception. By our mistakes more than by our successes are we likely to acquire knowledge; and in reviewing this case, certainly the initial

mistake was that of diagnosis. There is no doubt that there are cases so difficult to diagnose that it is not until the abdominal incision has been made—and sometimes not even then—that the diagnosis becomes perfectly clear; but in my case I think that had the patient been put under chloroform solely for the purposes of examination, points would have been revealed that might have rectified the diagnosis, and it is my determination in future always to insist on an examination of the patient under an anæsthetic where the slightest doubt exists before subjecting her to a serious operation. (I must, in justice to Dr. Smyly, say that he did not make any examination of this patient prior to operation.) Granting that the diagnosis of myomata had been made, would I have been justified in recommending operation, and if so, what operation? This patient gained her livelihood as a governess; she was suffering from discomfort, pain, hæmorrhage, and felt unable to attend to her duties, and all these symptoms developed within a very few months. The rate of growth was very rapid. Was not an operation indicated? Would not her condition—presuming these symptoms increased—have been a great deal more unfavourable for operation later on? The operation for the removal of the appendages, with the hope of arresting the growth of the tumour, might have been entertained, but in this case such an operation would have been very difficult, if not impossible, owing to their position at the back of this tumour, making them almost impossible to reach. Moreover, does removal of the appendages arrest the growth invariably? Tait says it succeeds except in the case of a soft œdematous myoma.

Another error was one of omission—namely, the fact of going to an abdominal section unprovided with a serre-nœud or a transfixion pin. Such an omission might have resulted in not being able to complete the operation when the

abdominal incision had been made. The invariable rule should be, whenever there is room for any doubt, to come provided to deal with the unexpected, as even the most experienced abdominal surgeons have made errors in diagnosis. I take this opportunity of returning my sincere thanks to Dr. Smyly for his invaluable assistance and advice during a long and trying operation, and also to Dr. Harley for the manner in which, by the successful administration of the anæsthetic; he never caused me one moment's anxiety as regards the condition of the patient.

If by remark or criticism on this paper, information be afforded which is useful or valuable to members of this Section, its object has been fully realised.

Dr. Atthill said that though errors of diagnosis could hardly be entirely avoided, still their occurrence would be rendered much less frequent were the patient examined while under the influence of an anæsthetic, as should happen in all doubtful cases. In Dr. Kidd's case the patient suffered from profuse menstruation, and that symptom pointed to the probability of the tumour being uterine, menorrhagia being of rare occurrence in ovarian disease; also the frequent desire to micturate is seldom observed in the latter, but is often complained of by patients who are the subjects of uterine myomata.

Dr. Kidd replied. In reference to what Dr. Atthill remarked about the probability of the tumour being uterine because of the occurrence of profuse menstruation and bladder symptoms, Dr. Kidd held that, as the menstrual periods were at longer intervals than usual, and as the tumour was diagnosticated as being ovarian with uterine adhesions, the element of doubt still remained, as prolonged intervals between menstruation and bladder irritation might be caused by an ovarian tumour with adhesions as well as with a purely uterine tumour. Dr. Kidd regretted that none of the members had touched on the point of the subnormal temperature for three weeks as being dependent on the suppuration caused by ligatures being expelled.