

## DYSTOCIA DUE TO FIBROIDS. INTRA-UTERINE DEATH OF FETUS. CRANIOTOMY.

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Mrs. R. Primipara. Aet., thirty-six.

First seen after ten hours of moderately hard labor, the last six hours of which there had been no progress.

Obstetrical examination showed, externally, an unusually large abdomen; uterus completely filling abdominal cavity. On the anterior surface of the uterus was a firm, movable tumor the size of a large orange; on the right side and fundus, several nodules the size of walnuts, on the left cornu a nodule the size of a coconut.

The fetal parts could not be palpated and no fetal heart was heard.

Feeble uterine contractions were evidenced on palpation.

External pelvic measurements, crestal, 28½ cm. Spinous, 22½ cm. Antero-posterior, 20½ cm.

There was no uterine tenderness.

Internally: head through the brim of pelvis, no fore waters, os dilated 1½ inches. No fibroid involvement of cervix or lower uterine segment.

Internal conjugate not felt.

The maternal pulse was 80, of good quality and regular but as the contractions of the uterus had about ceased and no progress had been made for six hours, operative interference was decided upon.

The patient was prepared with especial reference to asepsis. On account of the possibility of fetal life it was thought best to attempt a forceps delivery. Under ether the os was fully dilated manually and the forceps applied; repeated traction showed no advance of the head so the blades were removed. Introducing the hand by the head, a firm constriction ring was found encircling the infant's neck and shoulders, the ring including the center of the large fibroid on the anterior uterine wall. Carefully stretching the ring the hand passed it and the cord was found pulseless. Very little liquor amnii was present and escaped at this time. Craniotomy with Braun's cranioclast and the Smellie scissors was done and extraction of the fetus accomplished without difficulty. There was no maceration of the fetus showing a recent death. The uterine muscle contracted at once and in ten minutes the placenta came away naturally. Hemorrhage was absent and the uterus behaved well. A large intra-uterine douche of salt solution was given and a minor laceration of the perineum repaired. The maternal pulse rose to 140 during the delivery, but one hour afterwards dropped to 100.

The convalescence was uneventful, save for a slight pyrexia 100.8° F. and a scanty flow of lochia on the third and fourth days. This was met and relieved with copious intra-uterine douches of weak creolin solution followed by 3iv of 5% alcohol which was left in the uterus. There was no further pyrexia, the lochial discharge continued a trifle more bloody than usual but gradually ceased.

Involution was exceptionally slow; on the third day of convalescence the fundus was an inch below the ensiform cartilage and the fibroids were very easily palpated.

The case without the chart was shown to the students at this time and one of whom made a diagnosis of a full term pregnancy, palpated the fetal head and small parts, but strangely enough had negative results with his auscultation.

The patient was discharged at the end of three weeks, and final examination showed an irregular enlarged uterus extending about one inch above the symphysis.

She was advised and consented to, later on, have an operation for myomectomy or whatever seemed best when the abdomen should be opened.

The number of patients with uterine fibroids who pass successfully through pregnancy and labor is really most surprising.

The obstetrical importance of uterine fibroids depends upon their situation, — whether subserous, interstitial or submucous, and whether connected with the upper or lower uterine segment.

Subserous fibroids are of no obstetrical importance.

Interstitial and submucous fibroids in the upper segment of the uterus complicate parturition only by their tendency to produce irregular and feeble pains and thus prolong labor. They are afterwards attended by an increased liability to post-partum hemorrhage, a tendency to delayed involution, and an increased risk of sepsis from sloughing of the tumor. If the tumor growths are not situated at the periphery of the zone of the uterus which dilates, they do not generally give rise to any accident. In the lower segment of the uterus, they offer obstruction to the exit of the fetus; are liable to cause malpresentations and malpositions, and occasionally render delivery by the natural passages impossible.

Rupture of the uterus may take place in healthy uterine structures as a result of mechanical resistance offered to the advance of the fetus, or it may commence at the site of the fibroid where the uterine tissue is particularly thinned.

The conduct of this case with the terminal result naturally raises the query whether, if discovered early enough before the beginning of labor, some operative procedure might not have relieved the condition sufficiently to have accomplished a safe termination of the pregnancy.

The co-existence of a fibroid with pregnancy is not always an indication for operation, but it is extremely desirable to frequently examine women who have such tumors, to note the size, position and rapidity of growth, using such knowledge for the proper conduct of the individual case.

Statistics show that cases of pregnancy complicated with palpably large fibroid growths have a maternal mortality of over 30%, and a fetal mortality of probably 50%.

It has been easy to collect 100 cases of palpably large fibroids complicating pregnancy where myomectomy on the pregnant uterus was performed. In less than 5% was the pregnancy interrupted. The labors have occurred without incident, good uterine contractions have been present and no complications have existed. Subsequent pregnancies have occurred without incident.

Myomectomy is adapted to only certain classes of cases, — where the fibroid is subperitoneal or interstitial, where its size is not too great, and where the uterus may be handled without too much trauma. The hyperplasia of connective tissue in these growths favors the manual separation of the tumor from the uterine walls, therefore rendering operation easier for the existence

of pregnancy. Although Cæsarian section followed by enucleation of the fibroid would be the ideal treatment of obstructed labor due to a myoma, yet experience teaches that the great majority of the tumors as so situated are of such character as to render attempt at enucleation hazardous, and for these the Porro Cæsarian section, or hysterectomy is imperative.

Those fibroids which have already caused a premature or unsuccessful labor should be operated upon by enucleation, if possible, when the uterus is empty.

### Reports of Societies.

#### MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

THIRTY-THIRD ANNUAL MEETING,

HELD AT COLUMBUS, OHIO, OCT. 8, 9 AND 10, 1907.

THE President, DR. HORACE H. GRANT, Louisville, in the chair.

The scientific work was divided into medical and surgical sections.

#### LOCAL VERSUS GENERAL ANESTHESIA IN RECTAL SURGERY.

DR. G. B. EVANS, of Dayton, Ohio, believed that by using a local anesthetic previous to general anesthesia the amount of the general anesthetic was appreciably lessened; the dread and fear were diminished, also shock and danger. Therefore the combined method of narcosis, less anesthetic, suspending shock incident to conscious dread, as well as anesthetic shock, rendered more complete the operative area and consequently more satisfactory work. It was easy to operate on prolapsing piles, but not so simple to operate on piles above the sphincters, yet they demanded operative interference. Operation for hemorrhoids was serious, often attended by some shock, and the greatest caution should be observed to secure asepsis. He did not think it was best for patients that general practitioners should be taught that aseptic precautions at the time of operation and rest at home for a few days were unnecessary.

DR. BERNARD ASMAN, of Louisville, gave a few reasons for some unsatisfactory results in the treatment of ano-rectal diseases. A correct diagnosis was always a first essential, for without it all treatment was largely guesswork. Of all rectal ailments, anal fissure was ordinarily thought to be one of the simplest and easiest to cure, yet experience frequently proved it to be most unyielding. Ninety-nine out of every one hundred of the laity assumed that all ano-rectal troubles were hemorrhoidal in character, and it was not uncommon for them to approach the physician with a diagnosis ready-made, and to preface a description of the case in question with, "Doctor, I have piles." The doctor was then apt to accept the diagnosis with but a superficial examination, or perhaps no examination at all, and hence failure to afford relief followed. There were comparatively few cases of hemorrhoids, pure and simple; they were usually complicated by other local disease, perhaps requiring attention at the same time if a perfect result was to be expected. Cases were cited in point.

#### DISCUSSION.

DR. B. MERRILL RICKETTS, of Cincinnati, said that surgical anesthesia should be eliminated as far as possible in all work, especially now as capital opera-

tions could be done under local anesthesia. Local anesthesia for the treatment of hemorrhoids should not be denounced, nor should local anesthesia be recommended for all kinds of hemorrhoids. There were certain hemorrhoids that could be removed radically without anesthesia. He cited such cases. The trend of the times was not to put patients to bed for days and weeks for the removal of hemorrhoids, when they could be removed at the office of the surgeon or at the homes of patients with impunity. Hemorrhoids should be properly classified, and each class should receive a separate and distinct treatment, some with and some without anesthesia; some with and some without ligature; some with crushing and some with simple incision.

DR. J. RAWSON PENNINGTON, of Chicago, emphasized the importance of making a correct diagnosis. If a patient had a small contracted anus, with a few painful hemorrhoids, he or she should be given a general anesthetic and operated on. If the patient had a patulous anus, and the hemorrhoids were easily prolapsed, especially internal hemorrhoids, there was no need for a general anesthetic. He described his method of removing hemorrhoids. When the rectum was everted and the hemorrhoids were on the outside, with a pair of scissors they could be removed very readily, the rectum then dressed in extension, and putting into the bowel a rubber-covered tampon. When this was done there was no tissue under stress. Tissue under stress was not in the best possible condition to defend itself against infection.

DR. H. O. WALKER, of Detroit, had operated on a large number of cases of hemorrhoids, and had not yet had serious bleeding from the rectum. Hemorrhoids should be operated on under the same surgical principles as were carried out in operating upon other parts of the body. If there should be hemorrhage, it could be controlled by ligature or hemostatic forceps.

DR. E. B. SMITH, of Detroit, referred to the importance of making a complete and thorough examination. This could not be done under local anesthesia. He had never been able to do it, nor had he seen any one else do it with satisfaction. He had had the privilege of operating secondarily on patients who had been operated on under local anesthesia. He operated on these cases under general anesthesia.

#### THE FREQUENT INTERDEPENDENCE OF DISLOCATED KIDNEY, GALL-BLADDER TROUBLE AND APPENDICITIS.

DR. EARL HARLAN, of Cincinnati, summarized the salient features of his paper as follows: (1) That dependent pathology, accompanying the primary lesion of dislocated kidney, gall-bladder trouble and appendiceal irritation of a severe nature, is of frequent concomitant occurrence. (2) Many cases have undergone operation for appendiceal trouble or gall-bladder trouble wherein the causal factor was a dislocated kidney, the latter producing pressure interference to the bile outflow or bowel current. (3) All cases presenting for abdominal treatment, complaining of indefinite and recurrent distress, discomfort and pain, the attacks being accompanied with the presence of an excess of stagnant gas at certain points in the bowel, and in which the involvement of the stomach, gall bladder and appendix are more or less equal, should receive the careful consideration of the physician, in order that an accurate differential diagnosis may be made. (4) In the vast majority of cases a freely movable kidney presents no pathology on the part of the organ itself, and this immunity may cover a considerable space of time, after which there may appear symptoms of functional and mechanical disturbance on the part of the stomach, cholecyst and bowel. (5) On