

SELECT CLINICAL REPORTS.

(Under this heading are recorded, singly or in groups, cases to which a special interest attaches either from their unusual character or from being, in a special sense, typical examples of their class).

I.**Hysterectomy in a Case of Fibroid Tumour of the Uterus firmly bound down by adhesions.**

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IN a recent number of this JOURNAL I described a case of fibromyoma of the cervix uteri which weighed $17\frac{1}{2}$ lbs. The difficulty in extirpating this tumour was very great, but in the course of an operation performed since then upon a fibromyoma of the body of the uterus weighing only 1 lb. and a half so much difficulty was encountered that it appeared for a time that all hope of removal must be abandoned. It may be of interest to record the history of the case and to relate the manner in which the obstacles were overcome.

Mrs. G., 41 years of age, a patient of Dr. William Cullen's, was admitted into the Glasgow Samaritan Hospital for Women on the 6th of April, 1907. She had been married for 22 years, but was nulliparous. Menstruation had always been regular, and, with the exception of a "flooding" for three weeks in July, 1906, normal in every respect. It was not therefore on account of any menstrual disturbance that the patient had sought advice, but on account of difficulty in micturition, which had on several occasions necessitated the use of the catheter. It was then discovered that a uterine tumour existed.

Examination revealed that the pelvis was filled by a dense tumour of the uterus rising to two inches below the umbilicus and almost immovably fixed and adherent. The vagina was short and the infra-vaginal portion of the cervix practically obliterated.

At the operation on the 19th of April the fibroid uterus could be seen embedded in adhesions and surrounded by closely-attached coils of small intestines and by the cæcum and vermiform appendix. The bladder was an abdominal organ, and rose on the anterior surface of the uterus to a quarter of an inch below the fundus. The tumour was fixed and immovable. Both ovaries were invisible and non-palpable, buried beneath, and in, the masses of dense adhesions.

At first I hoped to separate the tumour and treat it in the ordinary manner, and I began by dividing the adhesions. It was necessary to cut them as they were too tough to be torn, and a good deal of bleeding resulted. The appendix was removed and the bladder was pushed down from the front of the tumour after transverse division of the peritoneum above it. After much difficulty the Fallopian tubes were freed from adhesions, clamped, divided, and removed, but the ovaries could not be dug out, and were left; it was impossible even to feel them. The growth was so closely adherent to the lateral walls of the pelvis and abdomen that a finger could not be got in anywhere to liberate it at the sides, and, similarly, the attachment posteriorly was so firm that it seemed as if vigorous attempts at separation would result in the rupture of some of the large arteries or veins. Further progress being therefore completely blocked, it appeared that all the time spent had been in vain, when it occurred to me to attempt enucleation. A transverse incision was made across the tumour near the fundus, the capsule was divided, and, with comparatively little difficulty, it was separated all round from the tumour down to the level of the cervix. The uterine arteries having been tied, the supra-vaginal portion of the cervix was cut across, the tumour removed, and the stump stitched over with silk. A deep cavity was thus left, the bleeding points in the walls of which were ligatured. So much oozing persisted, however, that long strips of iodoform gauze were packed in and the edges were united to the abdominal incision by two catgut sutures. The general peritoneal cavity was thoroughly flushed with saline solution, and before the patient was removed to her bed saline infusion into the infra-mammary cellular tissue was performed. Later on, strychnine was administered freely, the gauze was withdrawn on the following day, a rubber drainage-tube being substituted for a couple of days, and an uninterrupted convalescence ensued.

The tumour was a soft, simple, interstitial fibroid, and weighed, as has been said, one pound and a half. It was neither, therefore, very heavy nor very large, and the difficulty in its extirpation arose entirely from the presence of the adhesions which fixed it rigidly in its site. It is not possible to explain their presence as there was no history of any inflammatory attack, acute or subacute. The patient had enjoyed good health, marvellous to relate, and there was no intestinal trouble.

The cause of the adhesions is thus obscure, but their presence was only too much in evidence from the first. How similar cases should be treated is rather a difficult question to answer. This patient had suffered very little pain or discomfort, and some might argue that it were better for her to bear her comparatively slight ills than to brave the dangers of a severe operation. But consideration of the condition of the appendix, of the position of the bladder, and of the blocked pelvis compels us to believe that, after a varying time, troublesome

symptoms and dangerous complications would necessarily have supervened, and that it was right that every reasonable attempt should be made to remove the tumour. My opinion is that too long time should not be spent in such cases as this in attempting the impossible, *i.e.*, in freeing adhesions so dense, broad and vascular that the tumour is embedded in them and the surrounding organs and tissues, but that, the bladder having been pushed out of danger, the capsule should be divided and the tumour enucleated. Should enucleation be discovered to be impossible it would be easy and devoid of danger to stitch up the capsular wound and thus leave matters practically *in statu quo*. Howard A. Kelly, in his "Operative Gynecology," says: "There is one kind of myomatous uterus of which I have seen two examples, when the pelvic adhesions are universal, and the small intestines wherever they touch it are so firmly agglutinated that separation is entirely out of the question. I opened the abdomen in one of these cases, and concluded, from the red vascular appearance of the softish mass covered with lymph and adherent bowels, that the tumour was malignant; the patient recovered from the exploratory incision, and was in fair health a good many years later. I know of no way of reaching these cases." The case described by me was apparently of the same class; there was the softish mass of red appearance covered with lymph and adherent bowels, but fortunately a way was found by which the tumour was removed and with safety to the patient. This is not the place in which to discuss whether or not it is possible to operate with success upon every variety of fibroid tumour of the uterus complicated with the presence of such dense and universal adhesions. There may be some which are absolutely irremovable even by the most experienced and expert gynæcological surgeons, but I have described one extreme case and its successful removal.