Hirst (B.C.)

Clinical Notes

BY

BARTON COOKE HIRST, M.D.
Philadelphia, Pa.

REPRINTED FROM
THE AMERICAN JOURNAL OF OBSTETRICS
Vol. XXXI. No. 6. 1895.

NEW YORK
WILLIAM WOOD & COMPANY, PUBLISHERS
1895

CLINICAL NOTES.[1]

SERIOUS INJURIES TO THE PELVIC STRUCTURES IN LABOR, AND THEIR REPAIR.

THE history of the young girl from whom photograph No. 1 was taken reads like a page out of a medieval book on obstetrics. She was illegitimately pregnant, and, to conceal her condition from her family, took refuge with a midwife in the country. When labor came on it proved difficult, and at the end of four days of hard labor pains no progress had been made. The midwife then called in a physician, who applied forceps and extracted the child with great violence. The girl came under my care some four months after her delivery. She presented a pitiable appearance. Emaciated to an extreme degree, excessively anemic, too weak to stand upon her feet, and unable to walk a step, even if her strength permitted, from complete paralysis along the course of the peroneal nerve in the right leg, it seemed almost a pity she had survived her labor. On examination of the pelvic organs the following remarkable injuries were discovered: When the knees were separated the vulva gaped enough to admit a clenched fist. The recto-vaginal septum was torn through the sphincter and to within an inch of what was left of the womb. There was a transverse tear in the base of the bladder into which three fingers could be inserted. Below this was a mass of cicatricial tissue about an inch wide, in the lower or outer edge of which the lower third of the urethra ended as a blind pouch. There was no trace of a vaginal cervix. It had either been pulled off in labor or had sloughed off afterward. On both sides of the uterus there were deep pits into which the finger could be inserted up to its second joint. These were either abscess cavities or more likely deep tears into the

[1] Read before the Section on Gynecology, College of Physicians of Philadelphia, March 21st, 1895.

broad ligaments that had not healed up. There was of course incontinence of feces and of urine. There had been no menstruation since the childbirth, and the flow has not yet returned, although it is seven months since the girl's delivery, and she is now in the best of health.

I have operated on this patient five times in four months. At the first operation the transverse tear in the bladder was closed

FIG. 1.—Condition on entering hospital.

with the exception of an aperture, the size of a lead pencil, in the median line. Into this opening I proposed to implant what was left of the urethra. But four successive efforts to do this failed, for there was not enough vitality in the tissues below the band of cicatrix to insure union of raw surfaces, and I was obliged to rest content with what I had secured by my first operation. This, however, was satisfactory enough. The girl can

hold her water all night and for four or five hours during the day. If she rises suddenly to her feet, or is jolted or jarred in any way, there is a gush of urine. Otherwise there is perfect continence. I doubt if more could have been obtained had I made for her a new urethra or had fastened what was left of the original canal in the bladder, for the vesical sphincter was entirely destroyed in the slough and resulting cicatrix, an inch broad, that separated bladder and urethra.

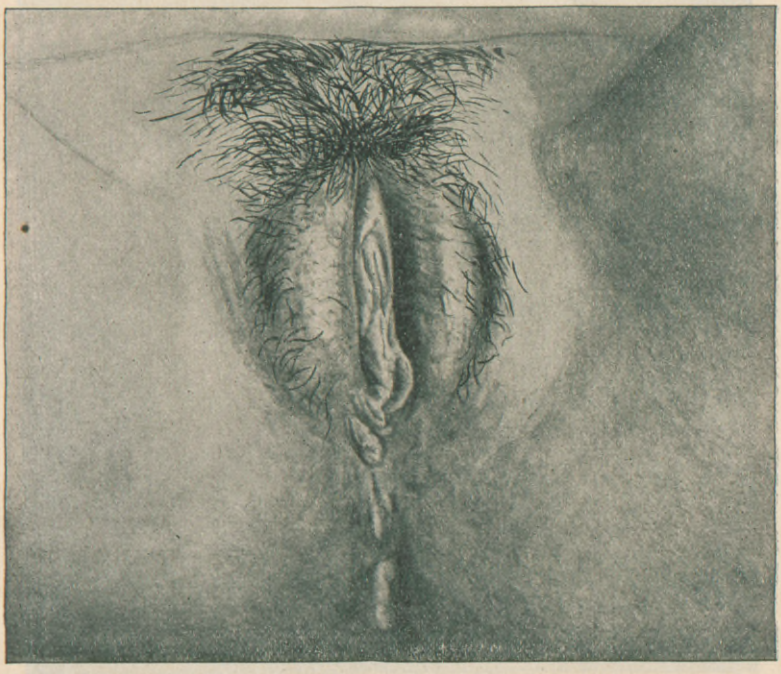

FIG. 2.—Condition on leaving hospital.

The repair of the recto-vaginal tear was effected in a single operation. It was difficult to approximate the edges of the tear, on account of the cicatricial rigidity of the vaginal walls. This difficulty was overcome by making deep incisions parallel with the edges of the tear and about an inch away from them. Rectal, vaginal, and perineal stitches brought the parts well together. I tried for the first time Leopold's plan of a restricted liquid diet and keeping the bowels locked for sixteen days. On removing the stitches the union was found to be perfect. The

young woman, as may be imagined, is now quite another creature. She has regained the use of her right leg and foot and walks with a scarcely perceptible limp. She has entire control of her bowels and, practically, of her bladder. Her emaciation and anemia have disappeared, and she is relieved of the horrible discomfort of a widely gaping vulva soiled constantly with a

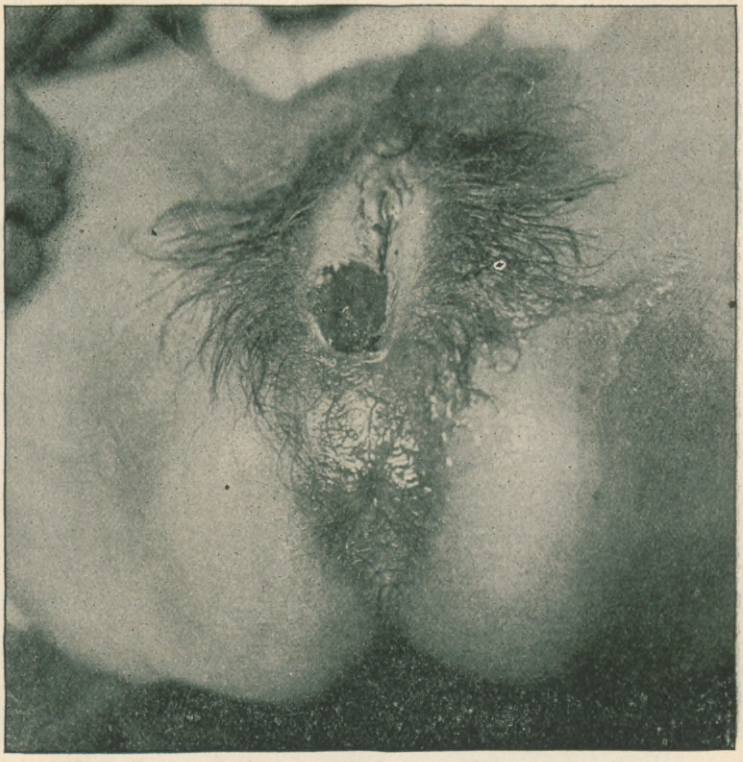

FIG. 3.

mixture of feces and urine, and, as she expressed it, "burning like fire" (Fig. 2).

EPITHELIOMA VULVÆ.

It seems to be the impression among gynecologists that epithelioma of the vulva is an incurable disease. In one of the cases about to be reported the late Dr. Goodell had refused to operate, although the condition was most favorable for operation, and there has been no recurrence now for a year (Fig. 3). In

a recent article in the *London Practitioner* (February), by D. Berry Hart, the author makes the positive statement that epithelioma vulvæ is sure to return, and yet a few paragraphs removed is a reference to Ruprecht's case of very extensive disease removed by an operation that included the removal of the inguinal glands, without recurrence after more than three years. Again, in a recent discussion before one of our gynecological societies the hopelessness of the operative treatment of epithelioma of the vulva was generally admitted. I am not yet will-

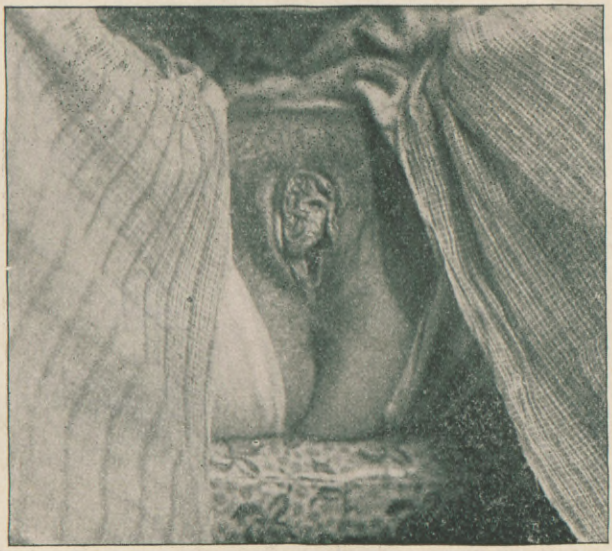

FIG. 4.

ing to subscribe to this belief. General surgeons expect success when they remove epitheliomata from other regions, and I am confident that in one of my cases, at least, the cure is permanent. If, however, the generally accepted view is correct, we should know it. And it is with a hope of eliciting discussion and initiating a collective investigation that I bring this subject before the meeting.

In Case 1 (Fig. 3) the whole right labium was removed, the raw surface seared with a cautery, and the edges of the wound were drawn lightly toward one another with catgut. The wound granulated well, there was instant relief from the pain

and mental anxiety that even small epitheliomata occasion, and there has been no recurrence in a year.

Case 2 (Fig. 4) required a most extensive operation.

Both labia were removed, with the mons veneris. The inguinal rings were exposed and the glands removed. The raw surfaces were seared and the edges of the wound approximated with catgut. The woman made a good recovery and left the hospital with a surprisingly normal appearance of the vulva, but I

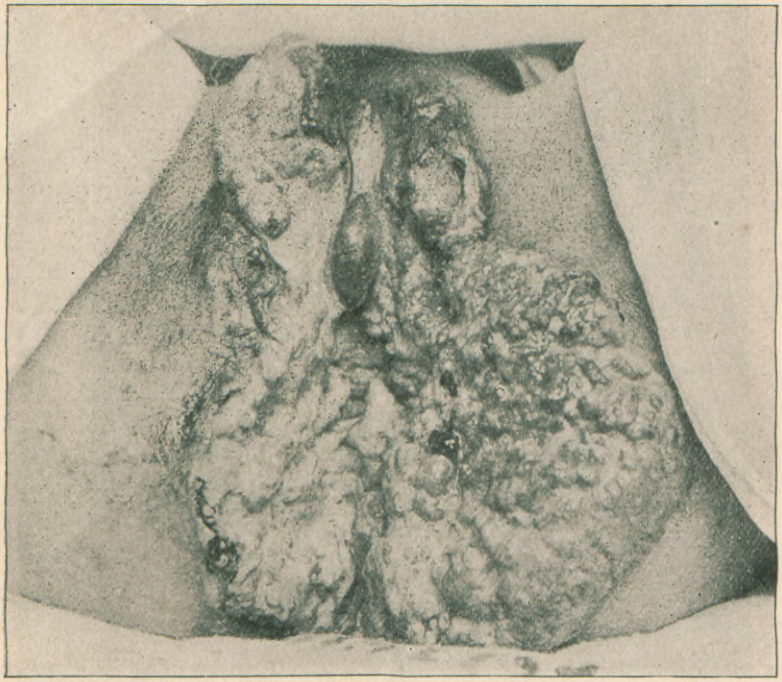

FIG. 5.

have lost sight of her and know nothing of her present condition. In addition to the importance of a correct prognosis in these cases, the diagnosis is a feature sometimes of great interest. There is a rare form of syphiloderm of the vulva so closely resembling epithelioma as to be differentiated from it only by the therapeutic test or by the microscope.

Fig. 5 represents a very extensive and inoperable epithelioma, from a photograph given to me by my friend Dr. Stelwagon. Compare with this Fig. 6. The latter represents a growth that

was thought by a number of specialists who examined it to be epithelioma, and I was about to operate on the woman when Dr. Stelwagon suggested that I first try antisyphilitic treatment as an experiment. Ten days of this treatment effected such improvement in the condition that all doubt of its nature was dissipated.

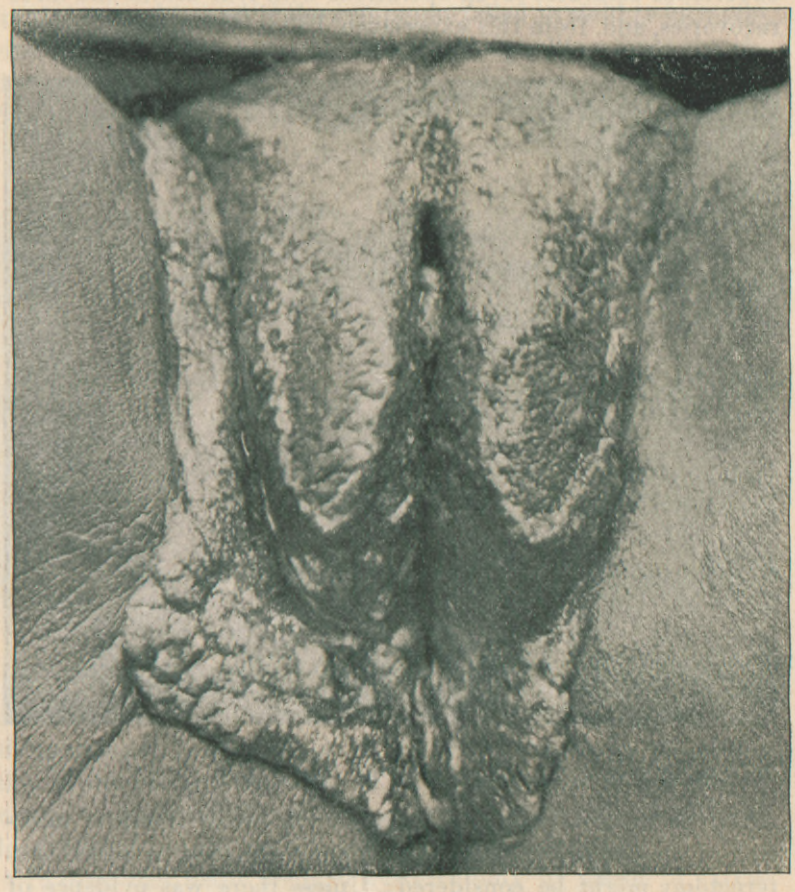

FIG. 6

HYSTERECTOMY FOR PUERPERAL SEPSIS.

The most recent and most important advance in obstetric surgery is the removal of all the pelvic organs that can be removed, when septic inflammation has spread from the uterine cavity to the body of the womb and to the pelvic connective tissue.

Women who were surely doomed a few years back can be saved to-day. It is little wonder, therefore, that we are seriously concerned with the question of indications and limitations of this operation, and that we desire as soon as practicable, by collective investigation and by observation, to establish clinical rules that will guide us in deciding for or against the operation. My own experience embraces seven operations with four deaths and three recoveries, and, from this experience, I should at present be gov-

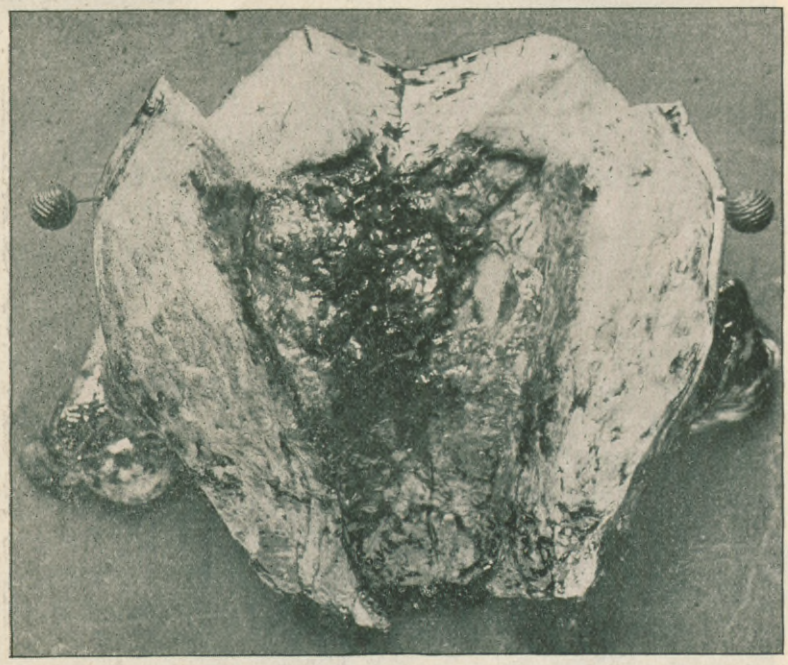

FIG 7

erned by the following considerations in a case of septic infection of the parturient tract after labor or abortion in which hysterectomy might be considered: Unless there was evidence of extension of inflammation to pelvic structures beyond the womb, in fixation of the latter and the development of inflammatory masses around it, I should be strongly disposed to decline the operation, even though thorough and repeated intrauterine disinfections and general stimulation failed to effect improvement of the symptoms. This rule excludes operative interference in diphtheritic endometritis, and rightly so, I think; I have ope-

rated on such cases (Fig. 7 represents one of them), but always too late.[1] There is not enough justification for operation in the first twenty-four hours, and after that it is too late. Suppurative and dissecting metritis would be excluded, too, for the first is often cured by a rupture of the abscess into the uterine cavity, and the second by exfoliation of the infected muscle. On the contrary, if the womb were fixed, if there were inflammatory masses around it, and if the symptoms failed to yield to intrauterine disinfection, to hot-water douches, to poultices over the abdomen, and to general stimulation, an abdominal section is called for and the operator must always be prepared to do a hysterectomy after the abdomen is opened, being influenced as to the

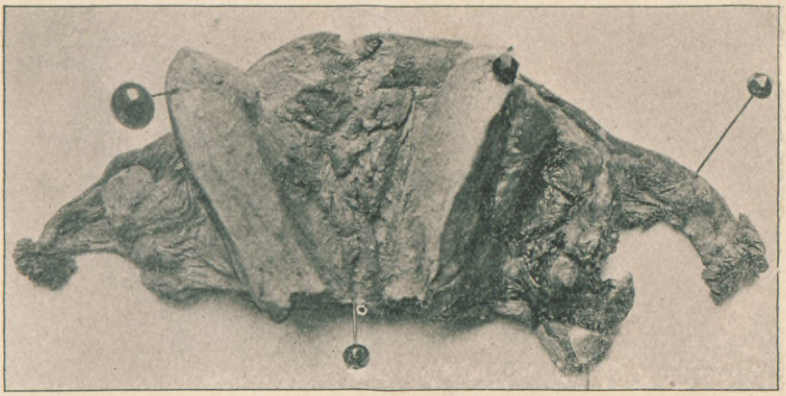

FIG. 8.—Hysterectomy for sepsis.

choice of salpingo-oöphorectomy, evacuation of abscesses with drainage and the removal of all the pelvic organs, by the condition of the pelvic structures. The common-sense rule would of course be observed that the operator should be content with the least radical procedure, if it promised to be adequate.

In cases that really demand hysterectomy by reason of extensive infection of pelvic structures, the outlook must always be gloomy, but it is astonishing to find as good results as may occasionally be secured in the most desperately ill women. The

[1] By diphtheritic endometritis I mean an inflammation of the endometrium with a dirty greenish-yellow or dark-brown exudate. I have never seen such a case recover under any treatment. The whitish exudates containing only streptococci and micrococci epidermidis albi are by no means necessarily fatal.

case from which Fig. 8 was taken could scarcely have been worse. I operated on the woman four weeks after labor, some three hours after I first saw her, but her general condition was so bad I scarcely expected her to survive the operation. The specimen shows pyosalpinx, ovarian abscess, large and multiple abscesses between the layers of the broad ligaments, and infection of the uterine wall. Fortunately the woman made an uninterrupted recovery, and is in fact better than she has been for years; for she gave a history pointing to the existence of pyosalpinx before impregnation, and it was probably to this infected focus that she owed her puerperal sepsis.

1821 SPRUCE STREET.