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LIGAMENTS
- II. COINCIDENT OVARIAN AND PAROVARIAN
CYSTS
- III. REPORT OF A CESAREAN SECTION AND
OF TWO SYMPHYSEOTOMIES

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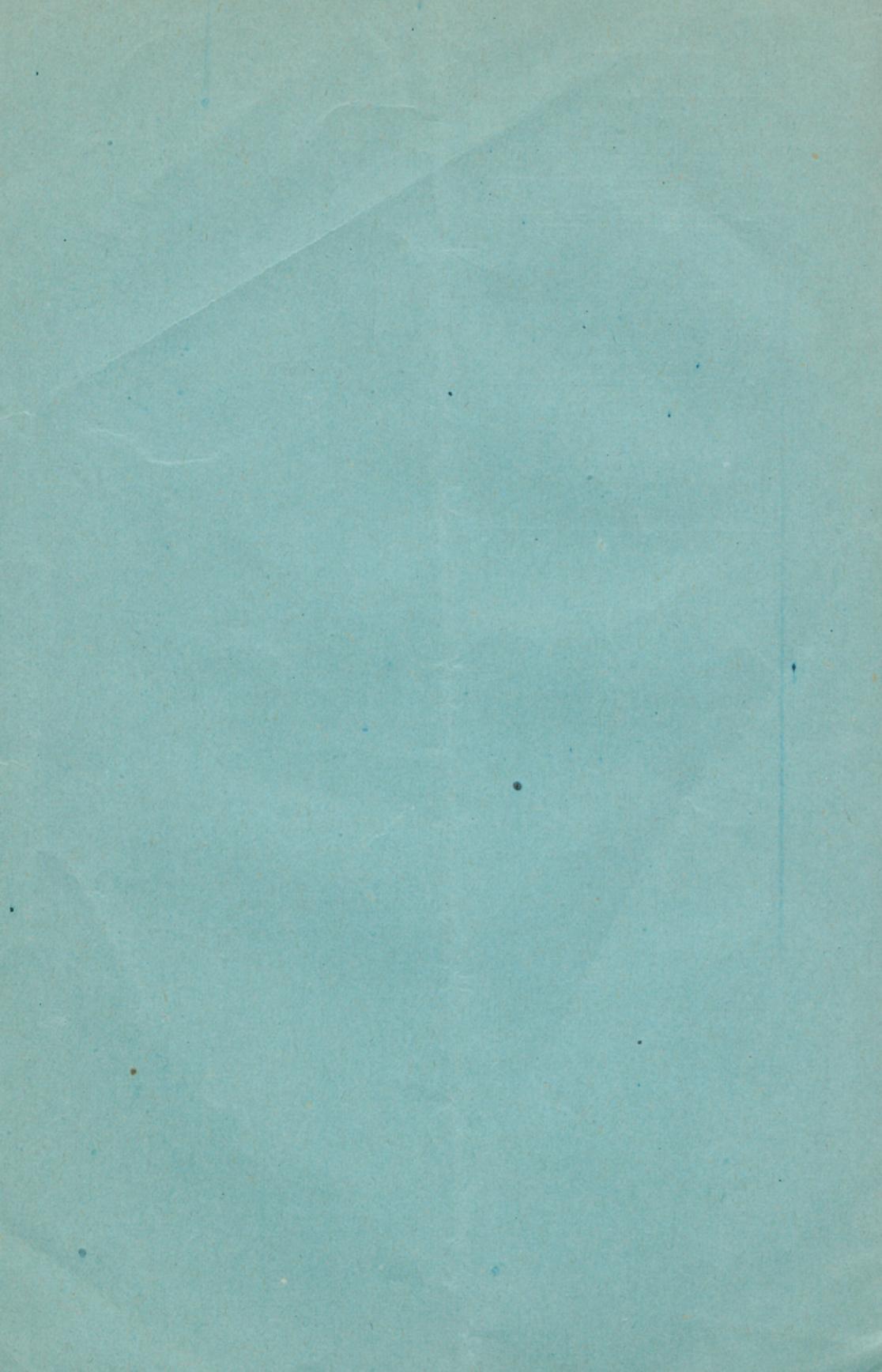
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CLINICAL NOTES.

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I. LARGE MYOMA OF THE OVARIAN LIGAMENT.

A MYOMA in the broad ligament, independent of the womb, is one of the rarest of all pelvic tumors. Some well-known gynecologists have denied its existence, but in all recent works on gynecology the possibility of myomatous growths from the ovarian and round ligaments is admitted, though most of the authors evidently have not themselves seen the condition.¹

Coe quotes Doran's case of a tumor weighing sixteen pounds. Pozzi refers to the cases of Sanger, Freund, Tedenat, and Bilfinger. The last could find only thirteen broad-ligament myomata reported up to 1887.

The woman from whom I removed this specimen (Fig. 1) gave the following history: She had had a sore feeling in the abdomen as long as she could remember. Married ten years, never pregnant. Menstruation always regular, but very profuse until twelve months ago, when it became scanty and has so continued.

The specimen itself shows its true character unmistakably. It has a small pedicle springing from the posterior layer of the broad ligament, on the outer side of which is a normal ovary. The tube, somewhat lengthened but otherwise normal, is thrown in a loop above and around the pedicle, and the fimbriated extremity was tightly adherent to the bottom of the broad ligament, beneath the pedicle. This I removed separately. The

¹ Read before the Section on Gynecology, College of Physicians of Philadelphia, April 18th, 1895.

² Keating's and Coe's "System of Gynecology"; Winckel's "Diseases of Women"; "American Text Book of Gynecology"; Garrigues' "Gynecology"; Kustner's "Gynakologie"; Martin's and Fehling's "Lehrbucher der Frauenkrankheiten,"



whole length of a normal broad ligament, without any separation of its layers, intervened between the pedicle of the tumor and the uterus. The latter was normal in size, position, and appearance. The right broad ligament, tube, and ovary were perfectly normal and were not disturbed.

The tumor weighs three pounds, and measures fifteen inches

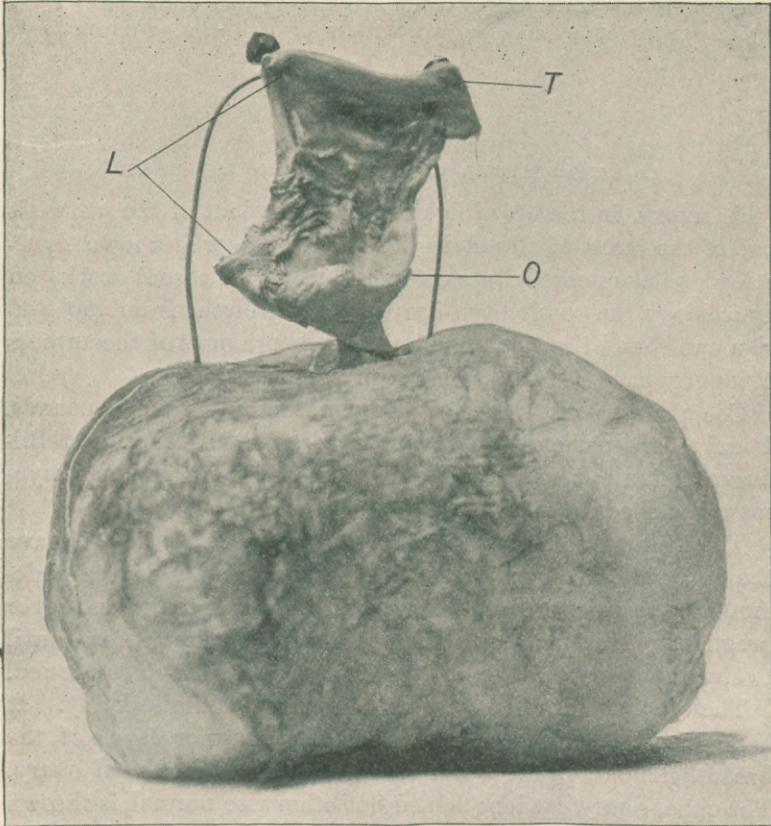


FIG. 1.—Myoma of the ovarian ligament.

in its smallest circumference. It has a few small cavities in its interior, containing fluid. A microscopic examination, kindly made for me by Dr. Stengel, shows it to be a leiomyoma. On examining the pedicle closely it appears that an hypertrophied ovarian ligament runs from the ovary to the tumor and is lost in it.

II. COINCIDENT OVARIAN AND PAROVARIAN CYST.

The specimen (Fig. 2) was removed from an insane patient in the Philadelphia Hospital. The woman was one of a number upon whom I operated this winter at the request of Dr. Hughes. They all had some diseased condition of the pelvic organs, such as prolapse, rectocele, lacerated cervix, pelvic tumors, etc. Our object was first to relieve the women of physical suffering, and then to watch the effect upon their mental condition of the improvement in their physique. So far one woman has regained her reason. All of them recovered and were benefited physically.

In my experience combined ovarian and parovarian cysts are



FIG. 2.—Po, parovarian, and o, ovarian cyst

rare; in fact, I do not recall another case. The ovarian cyst in this case was due to the abnormal distention of a Graafian follicle, and was monolocular.

III. REPORT OF A CESAREAN SECTION AND OF TWO SYMPHYSECTOMIES.

The woman upon whom the Cesarean section was performed had been in labor twenty-four hours when I first saw her. The cord had prolapsed some four hours before, and about a foot of it was lying in and protruding from the vagina. The vessels were pulsating fairly well. The pelvis was rachitic, with a conjugate of less than seven and a half centimetres.¹ There was a

¹ Spinae ilii, 23 centimetres; cristae ilii, 23½ centimetres; external conjugate, 16½ centimetres; conjugata diagonalis, 9½ centimetres.

double promontory. The woman was a primipara with a narrow vagina. The child's head, on palpation, seemed large, and it rested above the pelvic brim, freely movable. On bimanual palpation it was evident that the head could not enter the pelvis. The case was plainly one for Cesarean section. Symphyseotomy was inadvisable on account of the prolapsed cord, the extreme contraction of the pelvis, and the narrow vagina. I had once before lost an opportunity to perform Cesarean section because, while I went to fetch my instruments, a prolapsed cord was fatally compressed between the child's head and the brim of the pelvis. To avoid a similar mishap in this case I had the patient placed in the Trendelenburg posture over the back of a chair in bed until I was ready to operate.

After extracting the child I amputated the womb above the cervix and dropped the stump. I have tried all the forms of Cesarean section, and I like this best. The woman and child have done perfectly well. The latter had an occipito-frontal circumference of thirty-five and a half centimetres. All the head measurements were a trifle above the normal. The weight was close to eight pounds. This operation makes for me a personal experience of ten Cesarean sections—six as operator four as principal assistant. I have been told that this is the largest experience in the operation possessed by anyone in America.

The first of the two symphyseotomies to be reported can be described to the best advantage in connection with another case requiring high forceps, for the two together illustrate very well, I think, the best modes of procedure in dealing with labor obstructed by a contracted pelvis. There were at the same time in the University Maternity a rachitic dwarf with a flat pelvis whose conjugate diameter measured about eight centimetres, and a woman with a generally contracted pelvis whose conjugate was nine and a half centimetres. They were both primiparæ. With the former I anticipated serious difficulty. Labor, when it came on, was allowed to continue twenty-four hours. At the end of that time, in spite of strong pains, the head was still loose above the superior strait. The patient was prepared for a symphyseotomy, was anesthetized and placed upon the operating table. I then made an attempt, as I always do, to pull the head into the superior strait with axis-traction forceps, intending, if I failed, to cut the symphysis. Somewhat to my

surprise I succeeded with very little trouble, and delivered the woman, in a half-hour or so, of a living child that did well.

When the second woman fell in labor I apprehended very little trouble. She was allowed to have hard labor pains for twenty-four hours (being a primipara), and I then discovered that the head was still unengaged. She was anesthetized, and under ether I made a careful examination of the pelvis and of the head. The latter seemed to be of full size, but I believed it perfectly feasible to deliver with forceps. The attempt, however, failed completely, and after about a half-hour's work I gave it up for the time being. About six hours later I had the woman prepared for a symphyseotomy, etherized, and put upon the operating table. I made another attempt to deliver with forceps, failed again, cut the symphysis, again applied forceps, but, in spite of vigorous traction and as great a gaping of the symphysis as it was justifiable to allow, the head would not descend. Fearing some malformation in the child, I removed the forceps and made another careful examination, by which I discovered a cystic tumor on the back of the neck and behind the left ear, that had not been there before. I recognized, of course, a ruptured hydrocephalus, punctured the head, let out about a pint of fluid, and extracted the child without difficulty. I felt naturally chagrined that I had failed for the first time to diagnose hydrocephalus, and I made a careful study of the child's head to determine wherein I had been at fault. The head was stuffed with jute as full as it could possibly be stuffed, and the edges of the puncture wound were sewed together. It then appeared that the head presented none of the characteristic signs of hydrocephalus. None of the direct measurements exceeded the normal by more than one and a quarter centimetres. The occipito-frontal diameter was thirty-eight centimetres. The sutures did not gape excessively, nor were the fontanelles so large as to attract attention. The shape of the head did not suggest hydrocephalus at all, as may be seen by contrasting Fig. 3 with Fig. 4, the latter representing a case of mine in which there was no difficulty in the diagnosis.

The second symphyseotomy was performed upon a woman who had been four days in labor when I first saw her. She had had three children—two destroyed in labor, the third, a girl, born alive. The pelvis was generally contracted, with a conjugate diameter of nine centimetres. The child's head appeared

to be of normal size; it was unengaged above the pelvic brim. The woman was prepared for a symphyseotomy, etherized, put upon a table, and an attempt was made to engage the head with



FIG. 3.

FIG. 3.—Minor grade of hydrocephalus, unrecognizable by the ordinary tests.

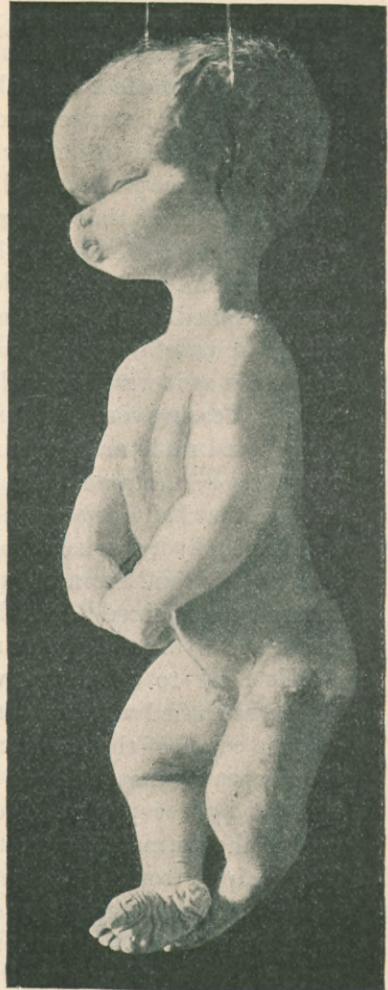


FIG. 4.

FIG. 4.—Well-marked hydrocephalus, easily recognized during labor.

forceps. This failed after twenty minutes' effort. The symphysis and the subpubic ligament were cut while the forceps was still attached to the child's head. It was then easy to pull

the latter through the pelvis. I have never seen the utility of the operation better demonstrated. The mother and child did well. This makes my sixth symphyseotomy, which Dr. Harris tells me (March 28th) is the largest number performed by any operator in America. Four of the children lived and all the women recovered. They all had afebrile convalescences except

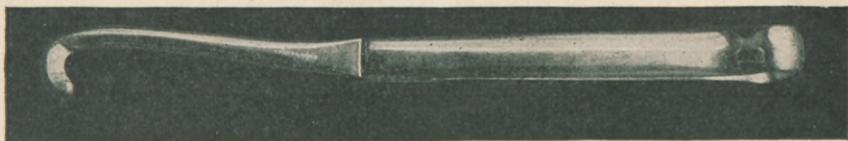


FIG. 5.—Knife for the subpubic ligament.

the first, who developed phlegmasia, not from the operation, but from the difficult labor that preceded it.

A few words are still in order about the technique of this operation. Increasing experience convinces me that it is one of the most difficult and troublesome of the obstetrical operations, both in its performance and in its after-care. The difficulties in the operation are decreased by the suprapubic incision and by the use of the Galbiati knife. This plan has the advantages of a wound more easily guarded from infection, of less danger of

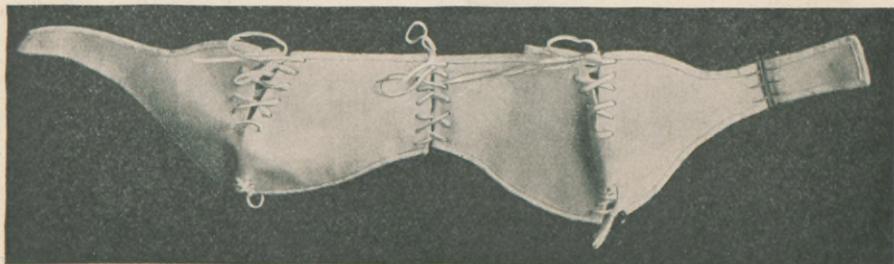


FIG. 5.—Hip-binder for use after symphyseotomy.

hemorrhage, and of less risk of injuries to the urethra and bladder. It has the disadvantage that the subpubic ligament is harder to cut. I have failed, I think, in every case to cut the ligament with the upward stroke of the knife that severs the joint, and I have been compelled to reinsert the knife to cut the ligament.

For this purpose the Galbiati knife is a clumsy implement, and

I have had constructed a special knife for the ligament that, I think, will prove convenient (Fig. 5).

The difficulties in the after-care of the patient are decreased by the use of a good hip-binder, and by the use, as suggested by Dr. Dickinson, of sand bags under the mattress.

I have employed the binder illustrated in Fig. 6 in three cases, and shall continue to use it. The anus, vulva, and urethra are left accessible, while the pelvis is well supported. It is wise, in addition, to pass a broad strip of rubber adhesive plaster around the hips, leaving the gauze attached to that portion of it which runs across the back.

