Cumston

THE CONDITIONS OF THE GENITAL ORGANS WITH REFERENCE TO VAGINAL HYSTERECTOMY FOR EPITHELIOMA UTERI.

CHARLES GREENE CUMSTON, B.M.S., M.D.,

Boston, Mass.

Assistant Professor of Surgical Pathology, Tufts College Medical School, Boston; Fellow of the American Association of Obstetricians and Gynecologists; Corresponding Member of the Association of Genito-Urinary Surgeons of France; of the Obstetrical and Gynecological Society of Paris; of the Pathological Society of Brussels, etc.

Reprint from November number, Vol. XII.

ANNALS OF GYNECOLOGY AND PEDIATRY

Boston, 1898.

THE CONDITIONS OF THE GENITAL ORGANS WITH REFERENCE TO VAGINAL HYSTERECTOMY FOR EPITHELIOMA UTERI.

CHARLES GREENE CUMSTON, B.M.S., M.D.,

Assistant Professor of Surgical Pathology, Tufts College Medical School, Boston; Fellow of the American Association of Obstetricians and Gynecologists; Corresponding Member of the Association of Genito-Urinary Surgeons of France; of the Obstetrical and Gynecological Society of Paris; of the Pathological Society of Brussels, etc.

In a recent paper read before the Section of Gynecology of the Suffolk District Medical Society (Remarks on the Pathology of Epithelioma of the Uterus with Reference to Operative Interference, Boston Medical and Surgical Journal, June 23, 1898), the writer considered the operative indications of epithelioma of the uterus, looked at from a pathologic standpoint, and in this short contribution, he desires to consider the indications furnished by the condition of the genital organs, and will begin with that of the uterus.

A cancerous uterus may be found either in an otherwise physiological condition, pregnant, or complicated by some pathologic condition, such as displacement, the presence of a neoplastic formation (other than epithelioma), or an inflammatory process.

The relation between pregnancy and epithelioma of the cervix forms one of the most interesting chapters of obstetric science, but this belongs more to the accoucheur than to the surgeon, and we will only briefly indicate the conduct that should be adopted by the latter under these circumstances. A pregnancy, complicating cervical cancer, gives rise to particular indications that are rather difficult to determine, because in this case it is not only the patient's life that is to be prolonged, but we should endeavor to bring to the world a viable fetus, if possible.

Two cases must be considered, viz., whether the uterus can or cannot be removed per vaginam, on account of its size. In the first instance, the condition is only present during the first half of gestation, and vaginal hysterectomy is possible on account of the considerable laxity of the vaginal tissues. Consequently, if the neoplasm is limited in extent, the uterus should be removed and the child sacrificed.

If the neoplasm has extended so far that hysterectomy will be

of no avail, local and general medical treatment is all that can be done. If it is supposed that pregnancy may go to term, if there is no pelvic tumor or induration of the vagina or cervix which would render labor difficult, the disease must be let alone, the patient's strength being sustained by suitable tonics, vaginal irrigations frequently and freely used, and proper dressings in cases of serious symptoms, such as hemorrhage, etc. On the other hand, if the life of the woman is in danger on account of a long and difficult labor, produced by a neoplastic infiltration of the vagina and cervix, it is proper, we think, to produce artificial labor.

On the other hand, if the uterus cannot be removed per vaginam, without removing its contents, two different conditions may present themselves, according to whether the disease is small in extent and can be removed, or on the other hand, has reached so far that only palliative treatment is indicated.

In the latter condition, a symptomatic treatment to bring pregnancy to or near term is all that can be done. If we are dealing with one of these infrequent cases where the uterus is of considerable size, and the neoplasm at its commencement, so that a radical cure may be hoped for, operative interference is called for. According to the conditions present, we may (1) induce labor, and after a few days do a vaginal hysterectomy; (2) Cesarean operation, followed by a colpo-hysterectomy; (3) supravaginal hysterectomy, followed by immediate vaginal extirpation of the remaining cervix; and (4) total abdominal hysterectomy of the pregnant uterus.

We will only mention inflammatory processes of the uterus which so often accompany carcinoma of the organ, be they consecutive to, or have been present before the neoplasm, as they are radically cured by hysterectomy, and do not greatly increase the difficulty of the operation, nor make the prognosis more serious. The same may be said of displacements of the uterus, or prolapsus of the genital organs; the latter condition, of course, renders the operation much easier, but it also increases the danger of hemorrhage.

The bearing on carcinoma of the cervix of uterine neoplasms, which in most instances are fibromata, is very different, and is a subject for much debate. The coexistence of a fibroid and a carcinoma of the cervix is not an infrequent condition to find, and when a woman who is under treatment for a fibroid presents fetid

discharges and severe hemorrhage, an epitheliomatous invasion of the endometrium is to be suspected.

Although, as yet, the transformation of a fibroid into epithelioma has not been distinctly demonstrated, an invasion of the fibroid by an epithelioma is now a well known fact, and the non-malignant neoplasm may be the factor in the causation of an epithelioma, developing in the neighboring uterine mucosa.

It has been shown by Schroeder that in a considerable number of cases, the chronic inflammation of the endometrium due to the presence of the fibroid first sets up a proliferation of the glandular structures. This process passes from the typical adenoma to an atypical form, namely, epithelioma. So, if a fibroid cannot in itself give rise to carcinoma, it can at least provoke it by means of the endometrium, and in such a case, symptomatic treatment should never take the place of radical operation.

Cases of coexisting fibroma and carcinoma of the uterus are to be treated by hysterectomy under certain conditions, which are the general indications for hysterectomy for fibroid, that is to say, the vaginal or abdominal route must be chosen according to the size of the fibroid. Vaginal hysterectomy for cases of fibroid coexisting with epithelioma, is only rarely indicated, but if the non-malignant neoplasm is small, the vaginal route will give fewer chances of infecting the wound with carcinoma.

We now come to the consideration of the conditions presented by the adnexa and the great frequency of epithelioma of the cervix during the period of genital activity of the female might lead one to suppose, *a priori*, that the coexistence of the latter with a pathologic condition of the tubes or ovaries is frequent. But such is not the case. The lesions of the ovaries that have been most commonly met with are secondary carcinomatous deposits and inflammatory lesions.

Secondary carcinomatus deposits within the ovary probably take place by the lymphatic system, and when once arising in this gland, they have a marked tendency to extend to the neighboring organs, viz.: broad ligaments, tubes, bladder, while at the surface of the diseased ovary, fibrous exudates and hemorrhages arise, which bind the intestine and peritoneum to the organ, and metastatic deposits extend to them.

The presence of carcinomatous metastasis in the ovaries is an absolute contra-indication for either vaginal or abdominal hysterectomy, because it is a certain indication that the neoplasm has

extended far beyond the limits of the uterus, and even if a radical operation were undertaken, there would be great danger from intestinal adhesions. Unfortunately, the diagnosis is difficult and requires a careful examination under narcosis, but it should always be done, because it is about the only lesion of the ovaries that is a contra-indication for hysterectomy.

Ovarian cystoma have been present in cases of cervical carcinoma, and in no way contra-indicate radical interference. If the ovary is cystic, but only slightly increased in size, the vaginal route is to be preferred, because ovariotomy is then a simple matter. When the cyst is larger and unilocular, with not very thick walls, the cyst may be aspirated after the uterus has been removed, and then the pedicle is tied off and the cyst removed. But such cases will be found to be the exception, puncture being difficult on account of the thickness of the cyst walls, and the tumor must be removed through the abdomen, when a total hysterectomy can be done at the same time.

Inflammatory and suppurative lesions of the ovaries, as well as those of the tubes, and also inflammatory infiltrations of the parametrium are no contra-indication to vaginal hysterectomy for carcinoma of the cervix, but here we must bear in mind that what may be taken to be an inflammatory lesion of these organs, may be malignant instead. Inflammatory infiltrations can be differentiated from the neoplastic type in that they are more elastic and supple, and still more inflammatory infiltrations, even when they are of recent occurrence, are rarely very extensive, while in the case of carcinoma they are hard, diffused, and invade almost the entire pelvis. In order to ascertain all these physical conditions, a combined rectal, vaginal and abdominal palpation is necessary under a complete narcosis.

A narrow or tight vagina may be an obstacle to vaginal hysterectomy, in which case the abdominal route must be employed, but two lateral incisions carried deeply into the cellular tissue will often give quite enough room to work with ease.

871 Beacon Street, Boston.