MUNDÉ (P.F.)

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REPRINT FROM VOL. XIV.
Gynecological Transactions.
1889.

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REPRINTED FROM THE
TRANSACTIONS OF THE AMERICAN GYNECOLOGICAL SOCIETY,
VOL. XIV., 1889.

PHILADELPHIA:
WM. J. DORNAN, PRINTER.
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THE METHODS AND LIMITATION OF TREATMENT FOR UTERINE FIBROIDS.

By Paul F. Mundé, M.D.,
New York.

The recent impulse given to the subject of the conservative treatment of fibroids of the uterus, chiefly by means of the galvanic current, has raised in my mind the query whether the pathological importance and pernicious influence of these tumors really warrant so much enthusiasm and such extravagant praise as have been accorded to this new method by a large part of the profession.

It is by no means my intention to detract either from the method or from the credit due its genial and persevering originator or his faithful disciples, but I cannot help thinking that the *relative* value of the treatment has been exaggerated and its indications extended beyond actual necessity. Being myself, to a certain extent, a believer in the value of galvanism as a substitute for the too ready use of the knife in fibroids, I am anxious to see this method relieved from the danger of suffering by the too urgent advocacy of its apostles, and to have it placed upon the secure and rational basis which it deserves.

Aside from the conservative treatment of fibroid tumors by electricity, there has been a recent revival of bold operative measures, chiefly among the laparotomists of Germany, for the removal of these same growths. The reports of brilliant and proportionately dangerous operations of this kind may be said to be steadily on the increase in the journals of that

country. Not content with removing the entire uterus with its fibroid additions by laparotomy, they have many times successfully opened the abdomen, split the peritoneal capsule of the tumor, enucleated the latter, and closed the wound by deep sutures. Furthermore, several operators have recently reported the removal of the myomatous uterus *per vaginam*—an operation which hitherto was supposed to be limited to malignant disease of that organ. I do not wish to criticise in an adverse sense these radical operations, since the names of the operators are, almost without exception, a sufficient guarantee for the correctness of the indication. But I am afraid that their example may tend to increase and enlarge the operative proclivities of gynecologists less fitted to judge of the necessity for such dangerous operations and less qualified by experience to carry them out.

My own observation leads me to believe that there exists among the profession at large more or less of a tendency to look upon all cases of fibroid of the uterus as requiring treatment of some kind or another, more or less active, more or less urgent. Within recent years I have been consulted a number of times by physicians in cases of fibroids which occasioned comparatively little discomfort to the patients, which were not visibly growing, and in which the future did not seem to offer any grave apprehensions, but for which the physicians in charge seemed to think speedy operative relief called for. Thus, I was invited to visit and operate upon a patient in Vermont "for uterine fibroid," and on my suggesting the advisability of bringing her to my office in order that I might see whether the operation was really called for, I heard nothing further of the case until, quite accidentally, I learned some time afterward that she had been operated upon by a Boston surgeon with a fatal result. Her physician had urged immediate operation, I was told, and she had to suffer for his haste. Again, a physician from New Hampshire requested me to operate on a patient of his for a fibroid, stating quite incidentally that a complication existed in the shape of a

pelvic abscess opening into the rectum. Evidently his idea was that the fibroid was the salient feature of the case, whereas I took the ground that in all probability the pelvic abscess produced more distress and required relief much rather than the uterine tumor. I could cite numerous instances where patients have consulted me for perfectly innocuous and not rapidly growing fibroids of the uterus which did not even cause the common symptom of menorrhagia, chiefly because their fears had become excited by the injudicious utterances of their physician or friends—an apprehension which I was able to allay very speedily by the assurance that there was absolutely no reason for worry or anxiety about the growth.

In the minds of very many ladies a tumor always means something that is likely or sure to kill. They do not understand the difference between fibroids of the uterus and tumors of the ovary, and I have usually found it necessary to explain wherein these growths differ as regards prognosis, rapidity of increase, and pernicious influence, before I could convince the patients that their tumor, being a fibroid, was comparatively harmless.

In corroboration of these statements, I can do no better than refer to a passage found on page 527 of Thomas's *Text-book of Diseases of Women*, edition of 1880, where, after speaking of the great frequency of uterine fibroids and their comparative trifling influence on the general health, he says: "Let the diagnostician who has discovered a uterine fibroid, and feels prompted to give a grave prognosis concerning it, bear these facts in mind, and he may be prevented from injuring his patient's comfort and his own reputation by so doing."

One of the first points for us to consider, it seems to me, is: Are fibroid tumors of the uterus so very common as to form one of the prominent ailments of the female sex? This question must unqualifiedly be answered in the affirmative, as is easy to demonstrate by reference to statistics and the records of our hospital, dispensary, and private practices. It is true that statistics differ widely as to the frequency of these growths,

Klob speaking of 40 per cent. of all women over fifty years; Bayle, 20 per cent.; and, on the other hand, Richard of only 7 out of 800 post-mortems, and Pollock only 39 out of 583 uterine cases. My own observation, which during the past three years covers 2974 cases of pelvic disease in the female, shows a record of 123 instances of fibroid of the uterus, or 4.14 per cent. This number may seem very small, but it must be remembered that only such cases consulted me as suffered either inconvenience from the tumor or were apprised of its presence by its increasing size. Hence it is exceedingly likely that fibroids are very much more common, but fail to attract the notice of their possessors. Of these 123 cases, but 62 required treatment of any kind whatsoever—in my estimation. The remaining 61—that is, about one-half—afforded their owners so little inconvenience or gave so little prospect of becoming troublesome, that not even a medical treatment was thought necessary.

Before proceeding to discuss the forms of treatment employed for the 62 cases referred to, I wish to state that the necessity for and the nature of the treatment depend, to a very large extent, upon, first, the location of the tumor; and, secondly, upon the symptoms which it produces.

Subperitoneal fibroid tumors seldom call for treatment for any other symptom than their rapid increase or the pressure produced by the growth upon the neighboring organs. *Interstitial* fibroids, on the other hand, manifest their presence both by their bulk and by the profuse menstrual flow which they induce, and this latter symptom in *submucous* tumors is the one which usually prompts the patient to seek relief. Tumors of the *cervix uteri* manifest themselves either by crowding down into the cavity of the pelvis, and the consequent interference with coition, defecation, micturition, and parturition; or else, if they are polypoid in nature, by the mucous or bloody discharge which they produce. According as the tumors are situated in one or the other of the above-mentioned locations, their symptoms differ, and the indications and nature

of the treatment vary. Thus, in subperitoneal fibroids the radical operations would be the removal of the diseased uterus by laparotomy or the checking of the growth of the tumor by the removal of the ovaries. In interstitial tumors, chiefly of the myomatous variety, laparotomy and enucleation of the growth, with preservation of the uterus; also, when this is not feasible, oöphorectomy; in the submucous variety, removal by splitting of the capsule and digital and instrumental enucleation *per vias naturales.* The persevering and judicious use of agents calculated to produce and maintain contractions of the uterus will aid in rendering these three varieties of tumors more accessible—the subperitoneal being pushed upward, the interstitial it may be upward, it may be downward, and the submucous always downward into the uterine cavity. The advisability, therefore, of a prolonged and persistent course of ergot, assisted by the faradic current, is obvious in those cases where it is desired either to render a subperitoneal or interstitial tumor less pernicious, or, on the other hand, to force an interstitial or submucous tumor nearer the normal uterine outlet, and the possibility of removal *per vaginam.*

I have thus repeatedly brought tumors of the latter varieties within comparatively easy reach by a few months of patience and oxytocic treatment. Repeated dilatation by tupelo tents, incision of the cervical canal, and, if necessary, splitting of the vaginal portion of the cervix, have materially aided in rendering the growths accessible. I wish to state at this point that my, I am happy to say, limited but sufficient experience leads me to fear most decidedly any attempt to remove a sessile fibroid situated near the fundus uteri through the utero-vaginal canal. I know of no more difficult operation in gynecological surgery, and of none more likely to prove disastrous to the patient. I should vastly prefer to follow the lead of the German operators who remove such growths by laparotomy and enucleation, or myomectomy, as they call this operation. Having now very briefly laid down the principles for operative procedure in cases of fibroids, I will proceed to

specify the methods of treatment employed in the 62 cases mentioned in my table.

UTERINE FIBROIDS FROM OCTOBER 1, 1886, TO SEPTEMBER 1, 1889.

	Number.	Treatment.							Summary.	
		Hysterectomy.	Oöphorectomy.	Curette.	Enucleation.	Torsion.	Galvanism.	Medication.	Treated.	No treatment required.
Corpus Uteri.										
Subperitoneal . .	64	6	2	...	...	...	4	...	12	52
Interstitial . . .	31	...	1	10	2	...	4	5	22	9
Submucous . . .	19	...	...	10	6	...	...	3	19	...
Cervix Uteri.										
Interstitial . . .	2	...	...	...	2	...	...	...	2	...
Polypi	7	...	...	...	...	7	...	...	7	...
Total . . .	123	6	3	20	10	7	8	8	62	61

With 2 deaths, both after hysterectomy.
123 fibroids among 2974 uterine cases, or 4.14 per cent.

In only 8 cases do I find ergot mentioned as the sole method of treatment. Of these, 5 were interstitial and 3 submucous. This treatment would seem to have been effectual, for in 2 of the 31 interstitial and in 6 of the 19 submucous cases the tumor was subsequently enucleated *per vaginam*. Undoubtedly in the other cases the hemorrhage must have been arrested, as no further treatment was required. In 10 of the interstitial and 10 of the submucous the hemorrhage was controlled by means of the sharp curette, and in 4 subperitoneal and 4 interstitial tumors the galvanic current was employed. The 4 interstitial tumors were treated by vaginal galvano-puncture; in 3 cases with the result of a complete absorption of the tumor after from one to five punctures respectively. In the 4 subperitoneal tumors only intra-uterine galvanism was employed (Apostoli's method), and merely a general improvement as regards cessation of hemorrhage and diminution of

pain was achieved. From 12 to 36 sittings were given in these cases. Enucleation *per vaginam* was practised in 8 cases of corporeal tumors, 2 interstitial, 6 submucous, and 2 interstitial cervical. Torsion was practised in all the 7 cases of cervical polypi.

Proceeding to the more dangerous operations, only in 3 instances was oöphorectomy thought indicated—2 subperitoneal and 1 interstitial; the result in each instance being perfectly satisfactory, and a diminution of the tumor with complete cessation of bloody flow taking place. Laparo-hysterectomy was performed in 6 cases, all of the subperitoneal variety, with 2 deaths, 1 from septic peritonitis and 1 from uræmia. In all cases the pedicle was treated by the extra-peritoneal method. In one instance the enucleation of a portion of the tumor was required, in order to form a serviceable pedicle. I have as yet had no opportunity to test the operation of myomectomy, and I confess that I have not been able to reconcile myself quite to the justifiability of removing the whole uterus *per vaginam* for myoma. Still, in this latter respect, future observations may modify my judgment.

Conclusions.

1. On general principles the rule may be laid down that fibroid growths of the uterus situated near the fundus uteri and showing no tendency to downward development, if requiring active treatment, are best reached from the abdominal cavity.

2. Tumors, on the other hand, situated near the internal os, and, either of their own accord or under the influence of oxytocic measures, showing an inclination to dilate that orifice and encroach upon the cervical canal, can almost always, after due preparation, be removed safely through the vagina.

3. About one-half of all fibroid tumors which attract the attention of their possessors and come under the observation of the physician require no active treatment of any kind.

4. Only interstitial and rapidly growing subperitoneal tumors call for or are benefited by galvanic treatment.

5. The removal of the hypertrophied mucous membrane of the uterine cavity by the sharp curette will often relieve, at least temporarily, the menorrhagia, which is the chief symptom present in the interstitial variety.

6. Enucleation, after splitting of the capsule by means of traction with the finger and some blunt instrument, usually offers a safe means of cure in cases of submucous corporeal and interstitial cervical tumors.

7. In certain cases of interstitial tumors which are so situated as not to be amenable to the compressing influence of ergot, but still affect the general health by profuse, uncontrollable hemorrhage, and again, in certain cases of rapidly growing subperitoneal tumors in which a thin pedicle cannot readily be formed, the removal of the ovaries may be confidently expected to check the hemorrhage and the growth of the tumor respectively.

8. Laparo-hysterectomy should not be lightly undertaken, and should certainly never be performed merely to relieve the patient of a fibroid tumor which does not affect her general health, and is merely inconvenient or unsightly.

9. The nearer the prospective menopause, the less likely is the fibroid to grow or cause trouble, and, therefore, *cæteris paribus*, the less are active or operative measures called for.