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Bloodless Vaginal Myomectomy.

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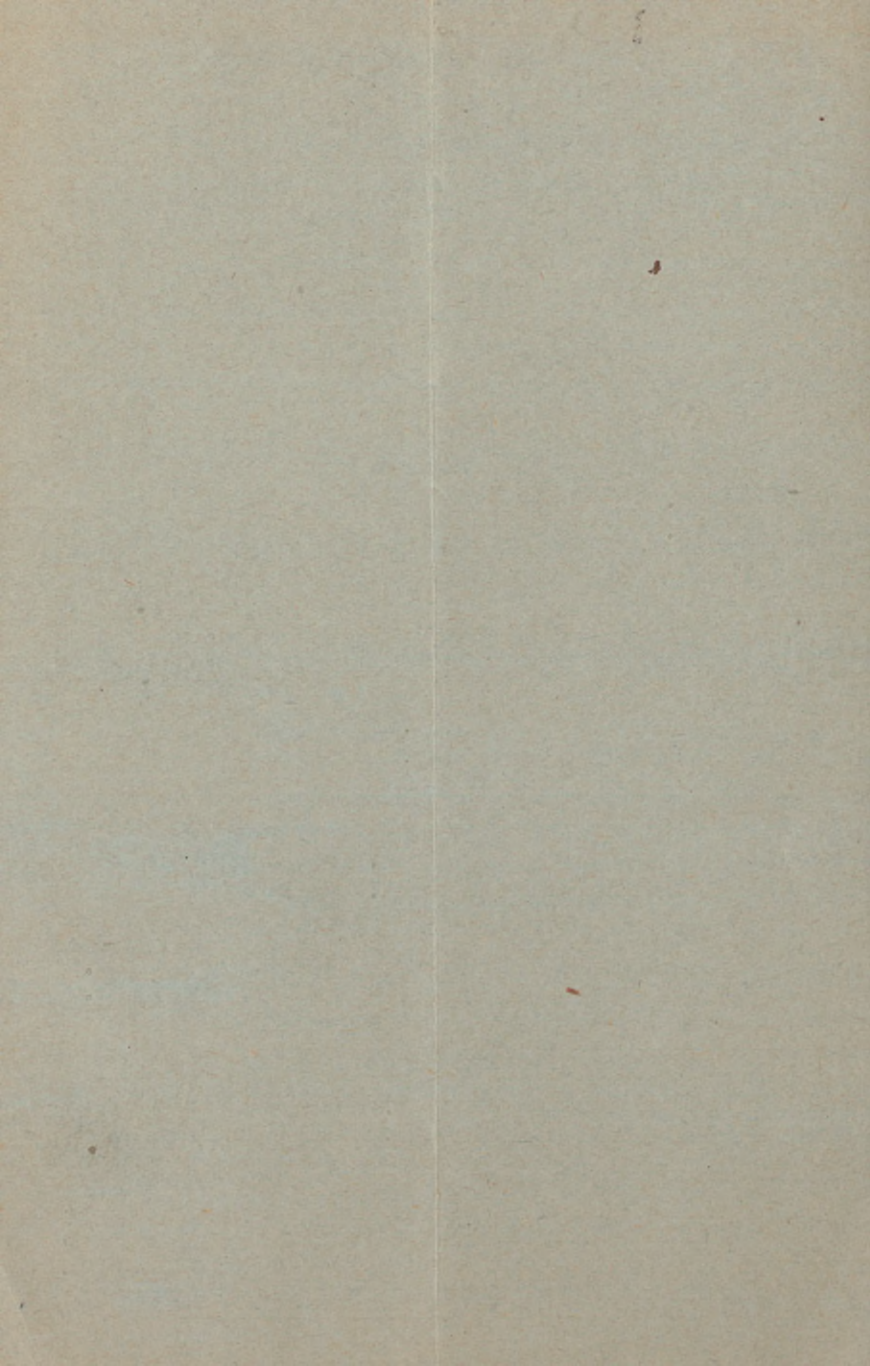
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BLOODLESS VAGINAL MYOMECTOMY.

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Probably no question of abdominal surgery has given rise to more animated discussion and bitter controversy than the treatment of uterine fibroids in all their three varieties—submucous, interstitial and subserous. After electrolysis failed to realize the hopes that were held out to the profession by Apostoli, lapara-myotomy and abdominal hysterectomy were once more eagerly resorted to, and led to many modifications in treating the pedicle so as to avoid hemorrhage and infection. Present indications are that all these methods will soon be discarded for the more correct and ideal operation of removing the uterus *in toto*. Arrest of growth of the neoplasms was sought by bringing about artificial menopause following oöphorectomy. More recently, ligation of the uterine and ovarian arteries has been recommended to effect atrophy of the growths and uterus. Vaginal enucleation is only applicable to such tumors as either can be pulled through the cervix, or those that appear as fibroid polypi, having their seat in the body or cervix of the uterus. The removal by morcellation, as originated by Péan, of large submucous myomata or pediculated fibroids distending the cavity of the uterus, although favorably recommended by many eminent surgeons, has never found much favor with the profession at large. The reason of this is the excessive hemorrhage that endangers the life of the patient. Some authors supplemented Péan's morcellation by first splitting the cervix bilaterally as far as the vaginal junction, and extending these incisions even into the body of the uterus itself, if necessary, to have the required room for their opera-



tions, and then ligating the uterine arteries to control hemorrhage. These preliminary incisions into the cervix and uterus have been regarded as such severe preparatory measures that most surgeons prefer abdominal hysterectomy.

The preservation of the womb of a young woman is a matter of most vital importance, and our aim should be a conservative plan of treatment that will remove the benign neoplasm, and will not carry in its wake sterility fraught with such momentous psychical and physical sequelæ. In the following case in my practice, I have successfully removed a fibroid tumor by morcellation, without any hemorrhage to speak of, by means of *temporary ligation* of the uterine arteries, having first caused obliteration of the cervix and dilatation of the os by vaginal packing, inducing contractions similar to the first stage of labor:

Mrs. H., age 28, of previous excellent health, gave birth five years ago to a living child, passing a normal puerperium. Since then her menses were regular until ten months ago, when about two weeks after menstruation, patient had a hemorrhage which lasted about two days, accompanied with pains in the back and groins. From then on, hemorrhage occurred at irregular intervals, with more or less pain. Four months ago, while constantly losing in weight and strength, patient noticed an increase of abdomen, which was very hard to the touch. Consulting a notorious quack, he pronounced the growth to be a cancer, and patient became alarmed about her condition. During the past eight months patient had lost forty pounds, and at the time of consultation weighed ninety-eight pounds. The lower abdomen protruded, the uterus was plain to the touch, enlarged and perfectly smooth, the fundus a finger's breadth below the umbilicus, corresponding in size to the fifth month of pregnancy. Auscultation revealed no sounds over site of uterus. The os was sufficiently dilated to permit the entrance of one finger, which felt a hard smooth mass. The digital examination caused quite a hemorrhage, so vaginal packing with iodoform gauze was employed to check it. Twenty-four hours after the packing was removed, the cervix was found obliterated, os dilated to the size of a silver dollar. Removal of the tumor, per vaginam, was proposed to the patient, and at the same time permission was obtained that if this should prove unsuccessful, abdominal hysterectomy should be resorted to, to remove the growth and uterus.

The idea suggested itself to me to try and prevent, or to reduce hemorrhage to a minimum by passing a temporary ligature *en masse* around the uterine artery. The vagina having been thoroughly irrigated with a 2 per cent solution of lysol and a Martin posterior speculum *in situ*, the field of operation was still further enlarged by retractors. With a strong volsellum forceps seizing the tumor, tumor and uterus were strongly pulled downward and to the right side in order to bring into view the vaginal junction of the cervix. With a large, strongly curved needle, threaded with a double thread of No. 12 braided silk, a ligature *en masse* was applied around the uterine vessels, by entering the needle well anteriorly to the transverse median line of the fornix, bringing it out equi-distant posteriorly to that line, and the two ends of the ligature were then securely tied. The uterus including the tumor being strongly pulled toward the left side of the patient, a temporary ligature *en masse* was applied to the uterine vessels on the right side. Morcellation of the fibroid was proceeded with by means of a pair of Sims' scissors, guided by the finger, which resulted in bringing forth forty-eight small pieces of the tumor until sufficient room was made to deliver the large remaining mass by traction. The weight of the tumor was nearly four pounds. Before the operation the tumor must have measured six and one-half inches in diameter. This was ascertained by enveloping the removed pieces in a towel and measuring the circumference of the enclosed mass. The uterine cavity was packed with iodoform gauze and the temporary ligatures were removed. Patient was given two hypodermic injections of ergotin. The time required for the operation was one hour, during which time the patient did not lose more than two or three tablespoonsful of blood. Twelve hours after the operation the intrauterine tampon was found forced out of place to more than half its extent, and showed very little bloody discoloration. The second day after the operation, the remainder of the tampon was removed, and as a precautionary measure the patient received a hypodermic injection of ergotin. Patient was kept in bed for twelve days, passing an uneventful time toward recovery, the temperature at no time rising above 99.2 on the evening of the operation. On the twelfth day patient left her bed, a convalescent, rapidly gaining in weight, until now she shows an increase of twenty-six pounds.

Despite the free anastomosis existing between the ovarian and uterine arteries, the circulation can temporarily be arrested for a sufficient time to allow of a bloodless operation being made on the cervix or in the uterine cavity, as was demonstrated in this case. While the anastomosis of the ovarian and uterine

arteries is quite free, I do not believe that the collateral circulation is as easily and quickly established as it would appear from accepted drawings illustrating the vascular supply of the uterus and its appendages. Dr. J. H. Barbat, Demonstrator of Anatomy in the Medical Department of the University of California, who kindly assisted me in this operation, has carefully dissected out the vessels supplying the female organs of generation in a well injected subject, that he might ascertain the exact anastomoses and sizes of anastomosing vessels between the ovarian and uterine arteries. Further researches on this subject are necessary to substantiate my skepticism and will be published by Dr. J. H. Barbat as soon as his labors are completed.

The danger of including the ureter in the ligature can be avoided if the needle is not passed too close to the cervix. Even should this occur no apprehension need be felt, as temporary compression of the ureter for such a short time will not cause any evil consequences. Puncture of the uterine artery is avoided by selecting a strongly curved needle of large size, taking care that the needle traverses a large semicircle from its entrance in the anterior fornix to its point of exit in the posterior fornix vaginae. Injury to the intima of the uterine artery from compression is not to be feared any more than injury to the vessels by using Esmarch's constrictor for bloodless amputations.

Bloodless operations are one of the triumphs of modern surgery, and with the great discoveries of the last fifty years, which enable us to operate without pain to the patient, and which have reduced to a minimum the danger of infection, conservatism should guide us in all surgical procedures. The time is fast approaching when the surgeon who removes an organ, except as a last resort, will have sinned against nature, and will by his very act pass sentence upon himself in the forum of Medicine.

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