

Wilcox, (R. W.)

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hysterectomy



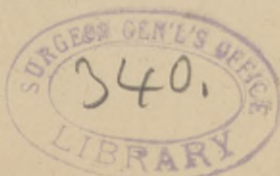
A SUCCESSFUL
CASE OF HYSTORECTOMY. F

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At the present time some apology seems to be necessary when one adds, to the already overburdened literature, the report of another successful case of abdominal section. But since this operation has passed out of the hands of the gynecologists, since no longer is the privacy of the abdominal cavity respected even by the general practitioner, all points connected with the operation should be carefully weighed that no one may entertain the propriety of performing this operation unless he has fully considered all contingencies that may arise as well as the treatment suitable to meet them. The fact that this operation was successful was not the motive for reporting it, but to call attention to matters of detail usually lost sight of in the presence of other and to the surgeon, more important subjects for consideration.

The patient Mrs. J. E.—came under observation Nov. 1st, 1883. Her age was forty-one, she had borne two children during a married life of fifteen years, had had two miscarriages, both of them since the birth of the last child, eleven years ago. The labors were normal. Her menstruation was regular in time, lasting three days, with normal flow, but some pain in the back before its appearance. For the last two years she had remarked an increase of size but considered it to be due to an increase of flesh. The tumor was discovered on examination about six months previous. For the last year had noticed some emaciation but no very great failure of health until six months ago, when she complained of loss of appetite. No other dis-

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ease was detected. Her chief annoyance was caused by the bulk of the tumor.

The operation was performed on Sept. 5th, by Dr. B. F. Dawson, assisted by the writer. The tumor was a multilocular, papillomatous ovarian cyst, the solid portion weighing five and one-fourth, the fluid contents eleven and one-half pounds. The mass was, in the main, divided into three cysts, each containing thick purulent fluid. There were many adhesions to the small intestines which were dissected off by the handle of the scalpel. There was found also a large surface of firm adhesion to the fundus and posterior surface of the uterus from which the tumor could not be detached. A Dawson clamp was placed around the uterus at the cervico-corporeal junction and the mass with the body of the uterus cut off. All adhesions were thoroughly cauterized with the actual cautery, especially on the left of the uterus and on the small intestines, some places also being ligated.

The most scrupulous cleanliness was observed by all concerned in the operation but no particular attention was paid to antiseptis. The writer's observation in a large number of abdominal sections that he has witnessed by almost every prominent ovariotomist, leads him to believe that each operator should look to himself rather than to any particular mode of antiseptis when he seeks to explain his fatal cases. A prominent feature of this operation was the use of perfectly clean, but wet towels, not only to thoroughly envelope the tumor at the various stages of its extraction, that none of its contents should enter the abdominal cavity, but as well to protect the sides of the incision from contact with the tumor and, indeed, to prevent any oozing from the cut surfaces from entering the peritoneal cavity. As usual, other frequently renewed towels were used to keep the surface of the abdomen warm.

The treatment of the peritoneum is very important when the pedicle must be retained without the abdominal cavity, and when in addition, as in this case, a drainage tube must be used. The writer had occasion to examine, *post mortem*, a number of cases of hysterectomy, in which the pedicle had been treated extra-peritoneally and in all, so far as he can remember, there were collections of either blood or pus between the stump and the edges of the incision and sometimes these collections extended to a considerable distance laterally, so that had the patients recovered, their convalescence would have been protracted by mural abscesses, conditions too often lost sight of by the operator, their importance being too little appreciated. And, indeed, the opportunity for the formation of ventral hernia is thus afforded. In this case the peritoneum was brought up and fastened to the skin by interrupted sutures, around both the drainage tube and the pedicle. Although, this at first sight might seem to produce a structurally weak abdominal wall yet the

final result would be, as shown, firm parietes. Deep sutures of silver wire were passed through the pedicle and walls and other sutures were used as in an ordinary case. The clamp seems to present some advantage when it is intended as a portion of the permanent dressing, since the pedicle is compressed so that its longest diameter presents in the line of the wound. The jaws are so constructed that the circulation is not entirely obstructed, thus permitting a slow separation by dry gangrene, giving less opportunity for septic infection. A glass drainage tube was inserted in the lower angle of the wound and the pedicle was touched with pure carbolic acid.

The operation lasted two and one-half hours, the patient's condition calling for several hypodermic injections of brandy during it. She reacted well. During the evening considerable bloody serum was removed from the drainage tube.

Second day: The temperature varied from 101° to 102° , the pulse 118 to 132, very weak. Enough opium was given to relieve pain and the patient was nourished and stimulated by rectal enemata. Both the head and abdominal Lister coils were kept on. Quinine also was administered by enema. The urine contained many granular, large and small, some hyaline casts, a small amount of albumen, some pus. On account of the weakness of the pulse, it was thought best to increase the brandy to three ounces daily. Marked tympanitis was present. Still considerable discharge removed from the tube.

Third day: Some improvement in the character of the pulse, urine unchanged, except less pus, temperature $100\frac{1}{2}^{\circ}$ to $101\frac{1}{2}^{\circ}$, pulse 118 to 122. Less serum in tube.

Fourth day: The temperature had fallen to $99\frac{1}{2}^{\circ}$, pulse to 106. Both coils were removed, to be replaced when the temperature should again rise. Some quinine deafness, so that quinine was diminished one-half and salicylic acid substituted for it.

Fifth day: Milk and lime water by the mouth, seltzer.

Sixth day: Temperature $100\frac{3}{4}^{\circ}$, pulse 94, patient very comfortable.

Seventh day: Temperature is steadily rising. The discharge from the tube is slightly yellow, turbid, no especial odor. On microscopical examination many leucocytes are found. The patient complains of pressure about the heart, numbness of left leg and arm. Some difficulty of speech, no deviation of tongue, pupils were normal. Suppuration was evidently taking place under the clamp and the pus was finding its way into the abdominal cavity along the side of the tube. The clamp was removed and a support devised to prevent the pedicle from falling downwards into the abdominal cavity and rupturing the adhesions between it and the sides of the wound.

This support is due to the ingenuity of Dr. Dawson and this was the second case in which it was employed. An Albert Smith retroversion passary of the largest size was moulded into

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the form of a Grailey-Hewitt anteversion pessary as modified by Thomas, except, of course, the transverse bar is wanting. A strong doubled silver wire is passed under the clamp, around the pedicle and twisted. The clamp being removed, the passary, moulded as described, is placed over the pedicle, the two ends resting upon the abdominal walls on either side of the line of incision and the four ends of the wires carried over and around the highest of the sides of the passary, or, if a large sized Grailey-Hewitt be employed, over the bar, and secured by twisting the ends together. Thus the pedicle is held firmly and easy access is permitted for dressing.

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From observation of this and other cases it seems that it may happen that the clamp is left in position too long, so that the wound secretions may be retained under it. Naturally the clamps that entirely shut off the blood supply in the pedicle fall off earlier, it may be too early for a firm union of pedicle to the abdominal wall.

The temperature gradually diminished, reaching $100\frac{1}{3}^{\circ}$, the pulse to 92.

Eighth day: Some sutures removed, patient comfortable.

Ninth day: Salicylic acid omitted. An impervious wall of lymph having probably formed about the drainage tube so that the general peritoneal cavity is shut off and no serum having been found in the tube of two days, it is removed. A roll of iodoformized cotton being substituted and twice removed.

Tenth day: Some elevation of temperature caused, presumably, by a mural abscess.

Twelfth day: Solid food. The place in which the tube was situated has entirely closed. Some discharge of mucus from the vagina. Ordered douch to be given. Temperature $99\frac{2}{3}^{\circ}$.

Fourteenth day: To be nourished entirely by the mouth.

Nineteenth day: The pessary support removed. The mummified portion of pedicle retained in the grasp of the silver wire separated by the Paquelin's cautery.

Thirtieth day: Is sitting up. Wound practically healed.

Fortieth day: Discharged from observation, perfect recovery. The patient now weighs as much as before the operation. Abdominal wall firm.

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Eighteen months after the operation, the patient reported herself without an ache or a pain, in perfect health.

New York City. September, 1885.

