Dudley. (A. S.)

Two cases of ovariotomy ×1

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TWO CASES OF OVARIOTOMY;

WITH REMARKS ON THE IMPORTANCE OF POSITION IN THIS OPERATION,

AND ON THE

SIMULTANEOUS AND RAPID DEVELOPMENT OF PELVIC ABSCESS AND OVARIAN CYST IN IMMEDIATE PROXIMITY.

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In reporting these cases my object is not so much to swell the number of such operations reported as to point out what I now consider my mistakes in them, and also to call attention to some points which might be of benefit to those of the profession who do not have the privilege of visiting the institutions of this city where ovariotomy is of almost daily occurrence.

Case I.—The patient was twenty-eight years of age, and first menstrated at fourteen. The period was irregular in return and always attended with some pain. She married at eighteen, and thirteen months later was delivered of a still-born child. It was a breach presentation, with which she was in labor several days. Instruments were not used, and the child had been dead about half an hour when delivered. The patient remained an invalid, and was confined to her room for three months afterwards. Her menses did not return for four years, and then recurred irregularly. At the time she became my patient it was her habit to flow moderately for three months, and then cease from three to six months. Four years after the birth of her child, and about two years before I saw her, she first felt an enlargement in the right

inguinal region. Its growth was gradual, and had been attended with very severe headaches, and occasionally nausea and vomiting. It was irregular in shape, easily movable, and seemed to be a multilocular cyst, with thick walls. To make a correct diagnosis was a difficult matter, in consequence of her continued menorrhagia. The latter, however, was relieved by thoroughly curetting the uterus, and she improved in general health for some months. But the increase of the tumor, with its attending constitutional symptoms, soon required surgical treatment, and an operation was performed for its removal. An incision three inches in length was made through the median line of the abdomen, and the patient was then turned upon her side and a Spencer Wells's trocar introduced. The growth proved to be a multilocular ovarian cyst with thick walls. Its colloid contents were so adhesive that the trocar was of little use, and I at once opened the sac sufficiently to admit my hand, and with my fingers broke up cyst after cyst within the main sac. This occupied considerable time, and as the patient failed quite rapidly, she was turned upon her back and the operation finished with her in that position. And, notwithstanding the extreme care taken to avoid it, some of the contents of the tumor escaped into the abdominal cavity. The growth had no adhesions except to the omentum for about half an inch, and this was ligated with catgut. The pedicle was long and slender, and was quilted with catgut, cut short and dropped back. The uterus and opposite ovary were, to all appearances, perfectly healthy; and after thoroughly cleansing the abdominal cavity, I closed the external incision with interrupted silver sutures. The patient did not bear the operation very well, showing marked signs of exhaustion, and reacted slowly with the aid of hypodermic injections of brandy, hot applications, etc. By the next morning, however, she had thoroughly reacted, and from that time her recovery was uninterrupted. Peritonitis did not follow, nor was there a sufficient rise of temperature to make it worthy of note. Aided by Dr. Whitmore, of Boston, under whose care she was subsequently placed, I was able to follow her case in its after stages, and will herein mention its most prominent features.

The operation was performed in November, and in the following January she was taken with cramp-like pains in the pelvis, extending into the thigh. About the same time an induration appeared behind, and to the right of the uterus, attended by some fever and increase of pulse. This was at first thought to be pelvic cellulitis, but its steady increase and attending constitutional symptoms soon evidenced a far graver malady. In March, in consultation with Dr. Whitmore, I saw

her again, and, after a careful examination, made the diagnosis of malignant disease. Tonics and stimulants, with opiates sufficient to relieve pain were given her; but the disease seemed to involve so much of the abdominal viscera that further operative measures were deemed unjustifiable. She died the following May, seven months after the operation. I made a *post mortem* examination three hours after her death, and found the abdomen very much distended with fluid, of which I removed a large pailful. This disclosed the growth to be as large as a man's head and involving not only the pelvic viscera but the omentum and small intestines as well. The latter were so matted together that I did not attempt to trace them through the growth. The left ovary was about the size of a fœtal head at term, and contained a fluid of varying consistency, together with several pus cavities. This I removed and had examined by a specialist in microscopical work, who pronounced it sarcoma of the round cell type.

The points in this case to which I desire to call attention are: First, the slow, steady development of the tumor, covering a period of nearly five years; also its long, slender pedicle, absence of adhesion, and its apparently benign contents. (I say benign, because, although I did not have the contents microscopically examined, I have since seen many of the same character that had been examined by the Pathologist of the Woman's Hospital and pronounced benign.) Also that the uterus, opposite ovary, and Douglas's *cul-de-sac* were perfectly normal at the time of the operation.

Nevertheless, within two months, malignant disease developed in the *cul-de-sac* and to the right of the uterus, in consequence of which this question presented itself to my mind: How much might I, by my method of operation, have been to blame for this unfortunate result? The patient had been turned upon her back before the tumor was entirely removed, and some of the contents had escaped into the abdominal cavity. This could and should have been prevented by keeping the patient upon her side until the sac had been completely drawn through the abdominal incision, a temporary ligature applied to the pedicle, and the wound cleansed with antiseptic solution. So far as I am able to learn, Dr. T. G. Thomas was the first to practice this method in this country. It is true that surgeons *now* frequently operate for the removal of ovarian growths with the patient upon her back during the whole time occupied. This practice, however, should be condemned, since it does not give the patient the best chance for recovery. It is next to impossible to drain and remove a cyst (and particularly a multilocular cyst) with the patient in that position, with-

out some of the fluid making its way into the abdominal cavity. While this fluid might appear to be of a non-malignant character, it might, when brought in contact with a freshly-congested peritoneum, transplant itself and reproduce disease of a malignant type. The surgeon's duty, therefore, should be to pay the utmost attention to the minor points in these operations. One of the most important of these should be to prevent even the smallest possible quantity of the contents of any growth from entering the peritoneal cavity. This may be accomplished by keeping the patient upon her side until the tumor is removed, the pedicle temporarily ligated, and the external wound thoroughly cleansed with carbolized water. Until then the patient cannot, with safety, be turned upon her back for the purpose of completing the operation.

Case II.—The patient was thirty-nine years of age when she first came under my care; at which time she gave the following history: She matured at the age of thirteen, with regular returns every three weeks, lasting from two to seven days. The flow was scanty and unaccompanied by pain. She had been married eleven years, but had never been pregnant. About six weeks before she came to me she had strained her back, she thought, while lifting a heavy tub, as she had experienced pain at the time. One week later she had taken a severe cold, and suffered with general neuralgic pains seemingly all over the body. Soon after her physician had been called in, and discovered a slight enlargement on the right side, which had rapidly increased in size until she came to me, three weeks later, at which time she presented the following symptoms: General health, poor; no appetite; a pale, anxious expression; some elevation of temperature and pulse, and pain in the right side. Local examination revealed an enlargement in the right side, low down, the size of a fœtal head. Vaginal roof hard and tender, uterus fixed. Her surroundings were such that she could not have proper care at home, and she was sent to the hospital. Further examination after admittance showed the enlargement to be, apparently, a simple cyst of the right ovary, with some form of pelvic complication. She was put upon tonic treatment, with hot vaginal injections, and applications of compound tincture of iodine to the pelvic roof, daily. These applications were made as she lay upon her back in bed, with Sims's speculum used over the pubes. I avoided, as far as possible, causing any traction upon the pelvic organs or giving her pain. Eight days after entering the hospital she was taken with violent cramp-like pains in the lower part of the abdomen, accompanied by a severe chill, which lasted half an hour. She recovered slowly

from the chill, but still continued to have the pain, for the relief of which morphia had to be given. From that time till the day of the operation she failed, having constant elevation of temperature and pulse, loss of appetite, and sleeplessness, except under opiates. She could take but little nourishment and had become very weak. The abdominal growth had rapidly increased in size, and the vaginal roof still remained very tender to the touch. Her condition had become so grave, and she showed such evident signs of suppuration either in the cyst or pelvic tissue, that I brought her to the operating room for the purpose of exploring the vaginal roof with an aspirating needle. After further examination both by Dr. Scott and myself, I decided to wait a few days more, hoping for some improvement in her condition in the meantime. None occurred, but rather the reverse became apparent, and she was prepared for operation. She was placed under the influence of an anaesthetic and an incision was made through the external abdominal walls. The growth proved to be a simple cyst of the right ovary, without attachment anteriorly, but it was so attached in the pelvis that it had pushed the uterus over against the left pelvic brim. The uterus had several small sub-peritoneal fibroids on its superior and posterior surfaces.

The patient was placed upon her right side, a large Emmet's trocar introduced into the sac, and the contents—a clear, limpid fluid—drawn off. I incised the sac sufficiently to admit my hand, and on passing the latter into the pelvis, my fingers at once came into contact with the pelvic roof. This, instead of being concave, presented an extensive convex surface, which gave a sensation of fluctuation. The apex of this convex surface seemed to be directly beneath the cyst pedicle, which had become somewhat spread out by distention from below. I selected this as the most favorable point for tapping, and passing a long curved trocar into the cyst sac, and guiding it by my fingers (I could not see the parts), I plunged it into the roof of the pelvis, and drew off through the canula fully a quart of extremely fetid pus. Still keeping the patient upon her side and the canula in position, I injected and reinjected the pus cavity with a warm solution of bichloride of mercury, 1 to 3,000, until it came back clear. I then withdrew the canula, and enlarged the opening sufficiently to admit my finger, with which I could feel several bands of necrotic tissue stretching in different directions across the pus cavity. These were easily broken up, and the cavity again washed out. The ovarian sac was then drawn through the external abdominal opening, and the patient placed upon her back.

None of the contents of either the cyst or abscess had escaped into the abdominal cavity. (The pelvic peritoneum was not inflamed.) The pedicle of the sac was, as I have already mentioned, spread out, and was attached to the pelvic floor. Under the circumstances this was very fortunate, for through it I was able to drain the abscess, without danger of the pus getting into the general peritoneal cavity. I made the drainage by drawing the pedicle up, and without ligating it. I cut away all the sac (except enough to make a funnel for the drainage of the abscess), and stitched the cyst walls to each side of the external abdominal incision with catgut sutures. A Tait's drainage-tube was inserted into the pus cavity, the external wound closed with silk sutures and dressed antiseptically, and the patient was put to bed. The operation lasted sixty-five minutes, during which time half an ounce of brandy was given hypodermically. The reaction was very slow, but her recovery was uninterrupted. Her temperature, which was 99.2° at the time of the operation, did not rise above 100.2°; and the pulse, which was 120, came down to normal in a few days.

The pus cavity was washed out every six hours with a solution of bichloride of mercury, 1 to 3,000. The drainage-tube was removed on the fifth day, having remained long enough to prevent a too early closure of the opening between the two cavities. The sutures were removed on the eighth day. Union by first intention had taken place, with the exception of the part where the drainage-tube had been inserted. Twenty days after the operation the patient sat up, the sinus still remaining open. (A probe could be passed to a depth of three and one-half inches.) This was then injected with a solution of equal parts of tincture of iodine and alcohol, repeated as often as required, until the sinus healed. The patient remained in the hospital forty days after the operation, and was then discharged cured. She was requested to report occasionally at the out-door department, and eighteen months after the operation reported herself well; since which time nothing has been heard from her.

The most important point in the interesting features of this case is the simultaneous, rapid development of an ovarian cyst and a pelvic abscess, so closely united that, although all the symptoms indicated the formation of pus, it was almost impossible to tell whether it proceeded from the ovarian sac or pelvic cellular tissue, for both the cyst sac and the abscess were so tense, and the pelvic roof so hard and unyielding, that, although a sense of fluctuation could be easily detected over the tumor, none could be obtained by bimanual examination.

Again, as the woman had never been pregnant, the abdominal walls were tense, and as the abscess was behind and below the uterus, the latter being pressed up against the left pelvic brim, the spreading out of the pedicle of the tumor by the upward pressure of the abscess afforded an otherwise almost impossible medium for safe drainage. Considering the condition she was in at the time of the operation, to have subjected her to along-continued drainage per vaginam would have been hazarding grave chances for her recovery.

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