Shoemaker (G. E.)

Case of hysterectomy ×××

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CASE OF HYSTERECTOMY BY LIGATION FOR FIBROMA.*

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The tumor shown was removed after months of electrical treatment which did no good. As the patient spent six months at two intervals in a private sanitarium it is reasonable to suppose that the electrical and other treatment was thoroughly given. It caused much pain, however, the loss of blood was not lessened and the tumor grew. The advice of the electricians to continue treatment was therefore disregarded and the patient came to Philadelphia for surgical advice.

She was thirty-seven years old, married seven years, one miscarriage, at five months and a half five years ago, with poor recovery, but no inflammatory complications. Periods lasted six to ten days and were free enough to exhaust from drain, though they were often delayed one or two weeks. The exhaustion of one period was scarcely recovered from when the next was due. There was moderate anæmia, no loss of flesh, a loose cough which had lasted six months, no lung consolidation, but the sputum showed tubercle bacilli. Occasional chilliness and perspiration with some hectic were noted. The tumor present was undoubtedly fibroid, and while developing from the posterior wall, could not be separated from the uterus, which was buried in it. It was freely movable and rose with the filling of the bladder to the umbilicus, sinking forward and two inches lower when the bladder emptied. This rising of the fundus was brought about in this way. The cervix was long and extremely flexible, so that when the bladder was empty the globular tumor (which was shaped like a symmetrically enlarged uterus at the sixth month of pregnancy) would fall forward, doubling backward the flaccid cervical segment. Vaginal examination now showed the tumor in contact with the anterior vaginal wall. On injecting the bladder with boric-acid solution, the uterus straight-

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ened, and then reached two inches higher in the abdomen, being displaced beyond reach of the vaginal finger by the distended bladder.

The condition presented the interesting problem: Given a case with incipient tuberculosis, a comparatively small fibroid causing no pressure symptoms, but with free bleeding from six to ten days, the weight and strength just maintained for one year at the verge of invalidism by constant care and repeated periods of sanitarium life, is hysterectomy advisable? Electricity had been tried and failed. Ergot had no effect on the bleeding, as usual. If the drain were removed, residence in the proper climate might cure the tuberculosis, it could not cure the tumor. Operation risks were increased by the cough, the danger of lung irritation and increase of the tubercular process by catarrhal pneumonia. The choice was in favor of hysterectomy, which was done without difficulty by the ligation method, the healthy cervix being allowed to remain. No drainage, buried wormgut sutures in the abdominal wall, which was completely closed. Good recovery followed, complicated however, by a catarrhal pneumonia of left lung partly induced on the tenth day by chilling of the room in a great storm. At no time was there the slightest redness or irritation about the abdominal wound which healed by primary union. Vaginal examination during the pneumonia showed absence of fullness or tenderness in the pelvis. The ligatures could be plainly felt by the sides of the cervix beyond the vaginal wall. She is now coughing much less than before operation. The question of operating on patients with cough is one of some importance. There is occasionally seen a dry cough, analogous to the cough of pregnancy, which is caused by the tumor itself. The path of the reflex is through sympathetic channels from the uterine plexus to branches of the pneumogastric nerve. The pneumogastric has direct connection with the cœliac plexus, hepatic plexus, splenic plexus, as well as the sympathetic in the neck, and it is no more difficult to explain a uterine cough than an ear cough through the auricular branch of the pneumogastric. It may reasonably be expected that a cough due to the tumor will stop with the removal of the irritant, but the presence of acute bronchitis, chronic bronchitis or tuberculosis demands separate consideration. Acute bronchitis should delay the performance of the operation for a few days. Chronic bronchitis adds a little to the risk of hæmorrhage and when severe adds a considerable element of risk of hernia by constant disturbance and dragging on the wound. The cough may, however, be controlled somewhat by sedatives such as hydrocyanic acid or co-

deine, and it is surprising how much patients are able to restrain cough when each expulsive effort causes pain in the wound

In genuine pulmonary tuberculosis, if advanced, operations of election are not usually justifiable. When phthisis is incipient, and the pressure of a focus of pus in the pelvis, or a tumor by its discharges removes the chance for general recuperation of the patient's strength, the intelligent resort to operation may be wisely made.

When, as in the case reported to-night, the patient's circumstances allow her to go to a climate which will cure tuberculosis, by removing the bleeding tumor first, though at somewhat increased risk, we enable her to exercise good generalship and defeat the enemy in detail.

Button Anastomosis, Operation by Dr. Murphy.

The specimen here shown was removed from a patient eleven months after a button end-to-end anastomosis operation which was done by invitation in this city, by Dr. J. D. Murphy, of Chicago, in September, 1893.

Dr. Murphy's operation was done to close a fæcal fistula which followed strangulated hernia in a patient sixty-five years old. How successful it was could with difficulty be learned from the patient. When, however, she came under my care nine months later with another strangulated hernia at the same point, the sac and coverings just separating with gangrene, she stated that fæces occasionally had continued to escape from the site of Dr. Murphy's operation, though more passed by the anus.

When I found her she had had no passage for three days; the vomiting was fæcal, the pulse poor, and the general condition bad. A protrusion of the size of the fist was tightly constricted at the base where it was attached to scar tissue at the side of the external opening of the right inguinal canal. The skin was greenish black and a watery discharge escaped from the fissure around the base, moist gangrene of all coverings of the hernia had occurred, but on cutting them all away with the scissors down to the abdominal opening, a loop of intestine was found protruding some four inches and in this were three well-established openings with rounded edges. The bowel though thickened and inflamed was not gangrenous and it was stitched into the opening with details which need not be mentioned here.

What had apparently occurred was this. Granting that at one time a perfect anastomosis had been secured, the same portion of gut had again found its way into a large hernial sac where it became adherent. The line of intestinal union must have now given way for the

patient stated that there was occasional fæcal discharge. The specimen itself shows the two ends of bowel united on one side only, for not more than one third the circumference. The escape of fæces into the sac is very likely what caused the gangrene of the sac and coverings without gangrene of the gut, and it is possible that the line of union gave way still further in the resultant inflammation. At my operation the bowel was not incised or torn.

Dr. Holmes afterward took charge of my ward for me and operated two months later to close the fistula. This gave the opportunity for securing this specimen. Dr. Holmes reported his operation before the County Medical Society November 14, 1894. The patient died.

Her intelligence was not great enough to enable me to learn whether she had had gradually developing obstruction or not. The possible contraction of anastomotic opening and subsequent giving way could not be proved. She declared she never had passed Dr. Murphy's button, which was probably an error.

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