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THIRTY-NINE CASES.

A Paper read before the Minnesota Academy of Medicine,
February 5, 1894.

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ST. PAUL.

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OVARIOTOMY. REPORT OF THIRTY-NINE CASES.*

By A. McLaren, M. D.

St. Paul.

In preparing this paper I have no desire to present a systematic consideration of the pathology, etiology, symptomatology, etc., of this subject, but simply to put upon record the cases upon which I have operated, bringing up for your consideration points which the cases themselves may suggest. The removal of an ovarian cyst was one of the gravest of all surgical operations but a few years since. To-day, however, with the marvellous advance in antiseptic and aseptic surgical technique, combined with the greater diagnostic skill of the whole profession, which has led to the earlier recognition and removal of ovarian tumors, this operation has become a comparatively safe procedure.

Surgeons are now agreed that an ovarian tumor should be removed at an early stage in its development, not allowing the tumor to remain endangering the patient's life, or make its later removal more complicated either on account of adhesive peritonitis, suppuration of its contents, hemorrhage into the sac, rotation of the tumor, or other complications which its presence may occasion. The removal of an uncomplicated, non-adherent cyst is a very easy and a comparatively safe procedure, and one which with ordinary surgical skill and cleanliness should be followed by a very small percentage of mortality. But when the operator meets an adherent, and especially a suppurating cyst, he must be prepared for one of the most difficult of all surgical operations with the most trying of complications, and a much greater death

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list. This is especially true when dealing with a suppurating tubo-ovarian cyst, lying as they usually do, deep in the pelvis, covered with adherent coils of intestines, the adhesions being as dense as cartilage, particularly in cases of long standing.

It is wonderful how nature is able to protect herself and confine the location of suppuration,and occasionally to even effect a temporary cure,by allowing the discharge of pus from the vagina,through the bowel, bladder or anterior abdominal wall. But because nature does produce such a cure in an uncertain number of these cases, I do not believe that it is wise in us to wait for this result, or to allow nature to select the point of discharge, for, although a few cases end fortunately, if the position of the opening allows a perfect drainage, others end in fatal septic peritonitis, some in old, long discharging sinuses, or in fæcal absceses, which end the life of the patient from septicæmia.

In this connection it would be an interesting question to decide how the excitors of inflammation reached the ovarian cyst. Probably in the great majority of cases the sepsis comes from either the Fallopian tube or from the appendix, but when these structures are apparently healthy, as has often been observed, where then does the inflammatory germ gain entrance? Some authors suggest the possibility of sepsis reaching the cyst through the intestinal or bladder wall, even when the peritoneal coat is unbroken, by a process of osmosis, as it were. It seems to me that it is much more reasonable to suppose that the inflammatory agent has passed through the tube, without leaving any visible trace, or that the intestinal or bladder wall has been temporarily broken.

I remember a case, which although I have quoted it before illustrates this point so pertinently that I will briefly describe it again. A young unmarried girl of 20, from Hudson, Wis., a patient of Dr. Sam Johnson, passed from the rectum a large quantity of pus. In a few days the sac refilled and her symptoms became quite alarming. I

assisted Dr. Wheaton, who removed the suppurating ovarian cyst, which contained about a quart of pus. No opening into the bowel could be discovered at the time of operation, but 48 hours afterwards, following a cathartic, she had a leakage of fæcal matter into the peritoneal cavity from a small, round ulcer on the anterior wall of the rectum, about six inches from the anus. This occurred before the days of Trendelenburg's posture; and it is possible that this position might have shown the site of the recent perforation.

My mortality following the removal of suppurating cysts, as you will notice from the table, has been considerable. It has seemed to me that the pus from a suppurating ovary is more intense in its virulence than from a pyosalpinx or an intraperitoneal abscess. There is no question that a newly formed abscess is more septic than an old one, for when pus germs are shut off from the atmosphere, they tend to run out, die and lose their vitality, although the pus does not change in its macroscopic appearance. To this is due the diversity of opinion existing among different operators, as to the best method of dealing with pus in the abdominal cavity at the time of the operation. One surgeon ascribes his success to irrigation with antisptic solutions, another to boiled water, a third to sponge or to gauze packing, but I am sure that much more depends upon the life vitality and character of the pus germs, than upon methods employed to cleanse the peritoneal cavity after the pus has once gained an entrance.

Dr. Maurice H. Richardson, of Boston, says in the *American Journal of the Medical Sciences*, speaking of pus in appendicitis: "A man with limited experience in these cases may have had good luck every time he has found the peritoneal cavity infected, and he may think the presence of septic fluids in the peritoneal cavity of small importance with proper cleansing and drainage. I have had at times case after case of recovery, even when there has been a total infection of the

peritoneal cavity. Then under conditions precisely similiar, * * * * case after case has gone on to a general fatal peritonitis, in spite of everything that I could do to prevent it. * * * * I am very much afraid of pus in the peritoneal cavity. * * * * Its presence in the abdominal cavity is one of the gravest conditions that can possibly occur."

It has been my practice of late, after exposing the abscess sac from above, to aspirate it, withdrawing its contents as thoroughly as possible; then to rely upon gauze packing and sponging to remove the pus, not using irrigation for fear of spreading the infection, relying upon gauze drainage for the after cleansing of the peritoneal cavity. The danger of irrigation is well shown in a case of Dr. A. Macdonald, where two weeks ago I opened an intraperitoneal puerperal abscess, one month after delivery, removing a pus tube from the right side and opening an abscess which contained 16 ounces of pus. The temperature which had been 103° the morning of the operation dropped to 99° that same evening. At the end of 48 hours I removed the gauze drainage and washed out the cavity with a small quantity of sterilized water containing a little boracic acid. In four hours the temperature rose to 104°; the pulse from 110 to 140. For three days her condition was extremly critical, but I am glad to say that she has now a normal temperature and pulse, and will undoubtedly recover [she eventually recovered]. My theory in this case is that the adhesion had not perfectly shut off the abscess cavity from the general peritoneum, and that the slight irrigation simply spread the sepsis over a larger surface.

Torsion of the pedicle from rotation of the tumor may occur in any large ovarian growth, but is more apt to happen when both ovaries are enlarged, or when the patient becomes pregnant. Pregnancy complicating an ovarian tumor is a dangerous condition, and one which should not be allowed to continue. The tumor should be re-

moved as early in pregnancy as possible for several reasons: First, because pressure may cause a miscarriage; second, the patient is liable to attacks of peritonitis, or following delivery she is more apt to have puerperal sepsis; again, pregnancy hastens the growth of an ovarian tumor. Another reason for an early performance of ovariotomy during pregnancy is that the abdominal incision may have more time to regain its normal strength and so avoid ventral hernia from the pressure of the rapidly enlarging uterus.

I have operated upon one pregnant woman, the operation being performed on the first of June last. I attended this woman in her first confinement nine months previous, when she was delivered of an acephalic monster. At the time of the operation she was three months pregnant. I had carefully watched the case, and could easily see that the ovarian cyst was rapidly enlarging from the stimulation of utero-gestation. The operation was a perfectly normal one, followed by an uninterrupted recovery. On the first of December last, Dr. DeWitt delivered her of a fine, perfectly developed, 9 lb. girl baby. As there is today no ventral hernia in this case, I will describe the method of closing the abdominal incision, which I have been in the habit of using for the past year or more, believing that this very serious test is evidence of considerable virtue in the method.

Mr. Frederick Treves in his text-book on surgery, says there is no linea alba below the umbilicus. This statement I cannot agree with, for although the linea alba differs in its fascial arrangement below the umbilicus, or more properly below the semilunar fold of Douglas, still the tendinous band which corresponds to the linea alba above is continuous from the ensiform cartilage to the pubes. The aponeurosis of the external oblique muscle is continuous throughout the whole white line; the aponeurosis of the internal oblique divides into two layers which surround

the rectus and form its sheath. Below the semilunar fold, which lies half-way between the umbilicus and the pubes, both layers pass in front of the rectus. Above this division the external layer unites with the aponeurosis of the external oblique, the internal layer with the transversalis fascia. All surgeons agree that the union of longitudinal muscular fibres is weak, and the strength of the anterior abdominal wall depends upon the fascial planes. Therefore, if after division we bring the fascial planes in apposition with the fibres of the rectus, instead of restoring the continuity of the fascia and reforming the muscular sheath we are apt to have a hernia in later months or years. Consequently great care should be exercised to reunite the divided fascia. If this is done with separate layers of buried sutures, the result will be as good as can be secured by any method. If only deep, bunching skin sutures are used, it must be a matter of good luck if the edges of the rectus do not interlap between the divided edges of the fascia. This may be prevented by avoiding the exposed edge of the rectus with the suture, picking up with the needle the external layer of fascia, then raising the edges of the muscle so as to expose the retracted posterior layer, passing the needle through this, so that when the suture is tightened the sheath of the muscle will be reformed and the muscle itself forced back from the centre of incision. Of course, if neither sheath of the recti has been opened this procedure will not be necessary, but how often do we open the abdomen without exposing one of the recti? In very few cases according to my observation.

In closing the abdominal incision I first bring together the peritoneum with a continuous catgut suture, and then the rest of the wound with a silk worm gut suture, which should not pass through the rectus, as described above, unless the muscle be unexposed, lying in its sheath. I believe that this is a much better method than the ordinary deep suture, but perhaps not quite as perfect

in its results as the union following the separate layer suture.

In 39 ovariotomies I have encountered but two dermoid cysts, one of these a multilocular cyst, one compartment containing the ordinary clear ovarian fluid. Recent observers have found beside the ordinary contents of the dermoid, such as sebaceous and sweat glands, bone, teeth, hair, etc., unstriped muscle, mammæ with areolæ and nipples containing cholostrum, and mucous membrane resembling gastric mucous membrane. One observer claims to have found part of the heart so perfect that it was recognized at once by his students; another a tongue, etc.

Dr. A. W. Johnston, of Cincinnati, in the transactions of the American Gynæcological Society, takes the position that the old idea of the infolding of the epiblast does not explain the formation of these growths; he believes that the dermoid is an attempt at reproduction by the ovary itself, the male germinal element not being present.

Since September, 1889, when I first commenced keeping the record of surgical cases I have performed 39 ovariotomies, 28 simple cysts, with two deaths; 11 supurating cysts with four deaths, and they will appear in the appended table. Of fatal caser the first non-supurating case died on the 21st day from intestinal obstruction. The patient had entirely recovered, had been out of bed for three or four days, when symptoms of obstruction manifested themselves, and an the 20th day I performed a secondary laparotomy; I found a knuckle of the intestine closely adherent to the stump; the separation of this adhesion did not appear to be sufficient so I quickly formed an artificial anus. But intestinal paralysis prevented the bowel from expelling its contents, and the patient died on the 21st day.

The second simple case died on the third day from the result of hemorrhage, perhaps associated with sepsis, following heroic attempts to remove a medium sized, densely adherent cyst, which was so

firmly fixed in the pelvis that it was necessary to leave a large piece of the sac wall. I have since been enabled to successfully remove almost a counterpart of this cyst by ligating both the distal and the proxymal ends of the ovarian artery, and then stripping the lining membrane of the cyst from its bed, in the same manner that one would remove a par-ovarian cyst.

Of the deaths following the removal of suppurating cysts, one case should hardly be included here, for it was simply an exploratory incision. The patient was suffering from general anasarca, following sepsis and pressure on the ureters of the inflammatory mass which filled the pelvis. The ovarian abscess sac connected with the bowel, so that its contents were fæcal in character. Her urine which was very small in quantity turned almost solid when boiled in the test tube. She lived about 36 hours after the exploratory operation, for it was deemed impossible to remove the cyst without killing her on the table, on account of the progy condition of the intestinal wall, and the dense, cartilaginous adhesions.

In another case it was first necessary to remove the uterus before the small, suppurating cyst could be reached. She died on the fifteenth day with symptoms of uræmia, the abdominal incision having opened and the urine commenced discharging through it, in the track of the gauze drain which had been used after the operation. It is possible that one of the ureters had been ligated, but if so, it is hard to understand why she should not have given more serious symptoms during the first ten days.

Several of the cysts which I have removed had been subjected to heavy galvanic currents under the impression that they were fibroid tumors, and this mistake I have seen made by many of the best diagnosticians, especially when the cysts were small, dense and contained thick fluid. Two patients have had after trouble with silk pedicle ligatures; in one I performed secondary laparotomy 17 months after the original operation, and found

a small abscess cavity at the horn of the uterus in which lay the offending ligature. The other patient passed the silk ligature from the bowel one year after the operation. Both of the patients have since entirely recovered their health. Many of these operations were performed three, four and five years ago. The results, although satisfactory in the main, I am sure can be very much improved upon with the added experience and the better knowledge of the best methods of sterilization of sutures, ligatures and dressings.

DATE OF OPERATION.	NO.	No. Cœliotomy.	Name and Consultant.	Color.	Age	DIAGNOSIS BEFORE ETHERIZATION.	OPERATION.
9-25-'89	1	8	Mrs. G. Author.	W	50	Ovarian cyst. Very long pedicle.	Ovariotomy. Wound closed in 7 minutes.
2-23-'90	2	12	Mrs. S. Author.	W	26	Ovarian cyst. First noticed 8 months ago.	Right ovarian cyst. Twelve pounds in weight.
7-20-'90	3	18	Mrs. I. Dr. C. B. Marshall	W	24	Ovarian tumor. Acute peritonitis.	Ovariotomy. Peritonitis. Suppurating cyst.
8-28-'90	4	19	Mrs. S. Dr. A. Sweeney.	W	35	Ovarian cyst. Had been treated with large galvanic currents.	Multilocular ovarian cyst 12 pounds in weight.
12-31-'90	5	25	Mrs. D. Author.	W	23	Ovarian cyst.	Ovariotomy left. Cyst 2 pounds.
1-17-'91	6	27	Mrs. S. Dr. Geo. M. Coon.	W	26	Ovarian tumor. Suppurating.	Exploratory incision. Abscess could not be removed.
2-17-'91	7	29	Mrs B. Author.	W	42	Ovarian tumor.	Ovariotomy. Ovary size of goose egg. Trachelorrhaphy.
4-29-'91	8	33	Miss B. Dr. W. T. Duncan.	W	26	Ovarian tumor.	Ovariotomy. Right ovary size of hen's egg.
6- 5-'91	9	37	Mrs. H. Dr. J. McLaren.	W	45	Ovarian abscess, connecting with the bowel.	Ovariotomy, left, as large as a goose egg and opening into the rectum. Right appendage also diseased and removed.
6-27-'91	10	39	Mrs. C. Dr. H. C. Johnson.	W	26	Ovarian tumor. Suppurating.	Left tubo-ovariarian abscess as large as an orange. Right fæcal tubal abscess.
8-13-91	11	40	Mrs. R. Dr. P. E. Jones.	W	37	Ovarian cyst. Probably suppurating.	Left ovarian cyst, containing Oij of clear fluid. Left pyosalpinx. Right appendage diseased and removed.
9- 2-'91	12	42	Mrs. C. Dr. K. Wirth.	W	43	Ovarian tumor. Suppurating.	Ovariotomy. Cyst 2 pounds, densely adherent.
10-24-'91	13	43	Mrs. S. Case No. 2.	W	27	Ovarian tumor. Has had several severe attacks of peritonitis since last operation.	Ovariotomy. Cyst of left ovary; 2 pounds.
4-11-'92	14	51	Mrs I. Author.	W	27	Ovarian cyst, with long pedicle.	Ovariotomy. Pedicle six inches long.
1-23-'92	15	52	Miss M. Dr. J. Macdonald.	W	50	Ovarian cyst.	Multilocular ovarian cyst.

COMPLICATIONS.	Drainage.	Recovered / Died	CONVALESCENCE.
Pedicle 6 inches long.	None	R	Died 11-20-'89. Autopsy, interstitial nephritis. No peritonitis
Slight adhesions.	None	R	Mural abscess. Left ovary became cystic and was removed 10-24-91.
Mesentery torn from small intestine.	Glass tube	D	Lived 24 hours. Autopsy, acute septic peritonitis.
Sac very strongly adherent. Trendelenburg's position first used	None	R	One small mural abscess; otherwise perfect.
Right ovary and tube suppurated 3 years ago. So adherent not removed.	None	R	Uninterrupted. Three early miscarriages since operation.
General anasarca. Fæcal ovarian abscess.	No record	D	Autopsy. fæcal ovarian abscess; acute nephritis.
Right multilocular cyst. Left tube and ovary diseased and removed.	None	R	Uninterrupted.
Right multilocular cyst.	None	R	Uninterrupted.
Intestine opened. Linear suture. 15 silk stitches. Trendelenburg's position.	None	R	Bowels moved on third day with a little blood. Temperature never above 101 deg. 9-4-'91 died, general tuberculosis.
Intestine opened in removing right appendage. Linear suture, silk.	Glass tube	R	Oct. 17, 1891. Abdominal incision opened. Discovered a green "core" with silk ligatures fastened by fæcal fistula. Soon closed. Cured.
Right tube very closely adherent to large intestine, which showed scar of perforation. Suture of external coats of bowel.	No record	R	Recovered. Never well until after second operation, 11-7-'93. Abscess at the horn of the uterus containing 2 ounces of thick, offensive pus; ligature.
Difficult enucleation.	None	R	Pelvic pains treated at dispensary for one year. Discharged improved.
None.	None	R	One year afterward became insane. Died in asylum.
None.	None	D	Intestinal obstruction on 21st day.
Universal adhesions. Necrosis of sac.	None	R	Uninterrupted. Cured.

DATE OF OPERATION.	NO.	No. Cœliotomy.	Name and Consultant.	Color	Age	DIAGNOSIS BEFORE ETHERIZATION.	OPERATION.
4-23-'92	16	53	Mrs. F. Author.	W	50	Carcinoma of the fundus uteri.	Tubo ovarian abscess on right side, containing Oj of pus, discharging through uterus.
5 13-'92	17	54	Mrs. P. Dr W. Smalley.	W	33	Sessile uterine fibroid on left anterior uterine wall.	Ovariotomy. Multilocular ovarian cyst, size of a fœtal head.
10- 6-'92	18	61	Mrs. Y City Patient.	W	34	Disease of both appendages. Left pyosalpinx.	Left tube containing 6 ounces of pus. Left ovary a multilocular cyst.
10-26-'92	19	64	Mrs. H. Dr. Sutherland.	W	30	Suppurating ovaries, perhaps opening into bowel.	Simple ovarian cyst. 1 quart of clear fluid. Pelvic peritonitis.
11- 7-'92	20	68	Mrs. M. Dr. Chas. Greene.	W	25	Ovarian cyst.	Dermoid tumor. Bone, teeth, hair, etc.
11-12-'92	21	69	Mrs. R. City Patient.	W	32	Ovarian cyst.	Left ovary as large as a hen's egg. Removed.
1-16-'93	22	75	Mrs. S. Author.	W	25	Left ovarian cyst and pyosalpinx. 11-4-'92. Exploratory laparotomy, and then opened and drained per vaginam. An intraperitoneal pelvic abscess.	Suppurating ovarian, containing 1 quart of pus, ruptured during enucleation.
1-17-'93	23	76	Sister J. Author.	W	49	Ovarian tumor. Had been treated with galvanic electricty as a fibroid. Several attacks of peritonitis.	Ovarian cyst so firmly adherent that it could only be partially removed.
2-25-'93	24	82	Mrs. H. Author.	W	25	Ovarian tumor. No tumor 2 weeks after delivery. Only child 3 months old.	Dermoid tumor. One-half dermoid, one-half clear serum.
3 -1-'93	25	83	Mrs. P. Author.	W	52	Fibroid uterus rapidly increasing. Perhaps malignant.	Dense ovarian cyst.
12-28-'92	26	74	Mrs. C. City Patient.	W	36	Pyosalpinx on left side as large as an orange.	Left pyosalpinx. One ounce pus. Ovarian cyst as large as a hen's egg.
5-29-'93	27	90	Mrs. S. City Patient.	W	22	Left pyosalpinx 3 months ago. Right pyosalpinx. Two ounces of pus removed.	Left ovarian cyst. Catarrhal adherent tube.
6- 1-'93	28	91	Mrs. M. Author.	W	25	Pregnant since 2-17-'93. Ovarian cyst enlarging.	Multilocular ovarian cyst. Pregnant uterus.
6-21-'93	29	99	Mrs. B. Dr. H. Day.	W	45	Left ovarian tumor as large as a naval orange.	Ovarian cyst on left side as large as a goose egg.
7-13-'93	30	102	Mrs. B. Dr. Dinwoodie.	W	40	Suppurating ovarian tumor.	Suppurating tumor could not be removed until after hysterectomy.

COMPLICATIONS.	Drainage.	Recovered / Died.	CONVALESCENCE.
Aspiration. Enucleation. Irrigation.	None	R	Uninterrupted. 7-15-93. Cured.
Had become separated from its pedicle by torsion. Universally adherent.	None	R	Uninterrupted. Cured.
Adhesions very dense. Right appendage also diseased and removed.	None	R	Uninterrupted.
Both tubes diseased and removed Adhesions very dense.	None	R	Eighth to thirteenth day, catarrhal enteritis. Oct., 1893, passed pus and ligatures from bowel. Cured.
Slight adhesions.	None	R	Uninterrupted. Cured.
Curettement and trachelorrhaphy.	None	R	Uninterrupted. Cured.
Very dense adhesions. Both appendages diseased and removed. Considerable hemorrhage.	Gauze	D	Eight hours after operation, anæmia and acute sepsis.
Very tedious. Considerable hemorrhage.	None	R	Died on third day. Hemorrhage and probably sepsis.
None.	None	R	Uninterrupted. Cured.
Right inguinal hernia, closed by silk worm gut sutures.	None	R	Uninterrupted.
Both appendages removed.	None	R	Uninterrupted.
Firm adhesions.	None	R	Uninterrupted. Now cured.
None.	None	R	Uninterrupted. Delivered by Dr. DeWitt 12-2-'93. Living child. No hernia.
Both adherent appendages removed.	None	R	Stitch abscess from peritoneal silk.
Baer's hysterectomy. Gas in cyst.	Gauze	D	Uræmia on fifteenth day. Urine had commenced discharging from the wound.

DATE OF OPERATION.	NO.	No. Cœliotomy	Name and Consultant.	Color	Age	DIAGNOSIS BEFORE ETHERIZATION.	OPERATION.
9- 2-'93	31	107	Miss J. St.Luke's patient	W	24	Chronic catarrhal appendicitis, with enlarged and tender ovaries.	Left ovary. One cyst larger than hen's egg.
10-28-'93	32	113	Mrs. S. Dr. F. W. Epley.	W	24	Tubo-ovarian abscess, or perhaps extrauterine gestation.	Right tubo-ovarian abscess. Ovary as large as a fœtal head at full term.
11-27-'93	33	119	Miss H. Dr.T.H. Johnson.	W	18	Right ovary three times as large as normal. Peritonitis; perhaps ovarian abscess.	Left ova y. One large, thick-walled cyst. Right multilocular cyst as large as a hen's egg.
12-16-'93	34	120	Mrs. W. Dr. F. W. Epley.	W	30	Left ovarian cyst.	Left inflammatory ovarian cyst.
2-22-'93	35	80	Miss M. City Patient.	W	30	Double pyosalpinx.	Right ovary as large as a Mandarin orange. Right tube, 2 ounces pus; left tube 1 ounce pus.
3-21-'93	36	86	Mrs. S. Dr. C. E. Riggs.	W	37	Enlarged and inflamed right ovary. Uterus retroflexed and bound down.	Right ovary as large as a turkey's egg; multilocular.
8-26-'93	37	106	Mrs. S. Author.	W	50	Ovarian tumor.	Right ovary as large as a goose egg. Baer's hysterectomy.
12-25-'93	38	121	Mrs. L. Dr. Geo. McLain.	W	31	Inflammation of both appendages. Uterus retroflexed.	Right ovary contained one cyst as large as a hen's egg.
2- 4-'94	39	124	Miss B. Dr. J. McLaren.	W	35	Ovarian tumor, inflamatory in character.	Suppurating tubo-ovarian abscess. Oj of very offensive pus.

COMPLICATIONS.	Drainage.	Recovered Died	CONVALESCENCE.
Left ovary removed.	None	R	Uninterrupted.
Left pyosalpinx. Also removed 1 drachm of pus.	None	R	Uninterrupted. Microscope at time of operation showed many dead pus cells.
Both removed. Cystitis.	None	R	Delayed by the cystitis.
Dense adhesions. Ligated both ends of ovarian and removed.	None	R	Cystitis for two weeks.
Both appendages removed. Very dense adhesions.	Gauze	R	Uninterrupted.
Right ovary covered with rough palpillary growths. Both appendages removed.	None	R	Uninterrupted.
Fibroid uterus as large as a fœtal head at full term.	None	R	Uninterrupted.
Both appendages removed. Ventral fixation. Union with silk worm sutures.	None	R	On the tenth day passed a small quantity of sponging gauze from the rectum. A great deal of pelvic pain ever since.
Very dense adhesions. Sac ruptured during enucleation. No irrigation.	None	R	Uninterrupted. Temperature has never risen above 99 deg.