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THE REMOVAL OF AN UNUSUAL NUMBER  
OF ABDOMINAL STRUCTURES

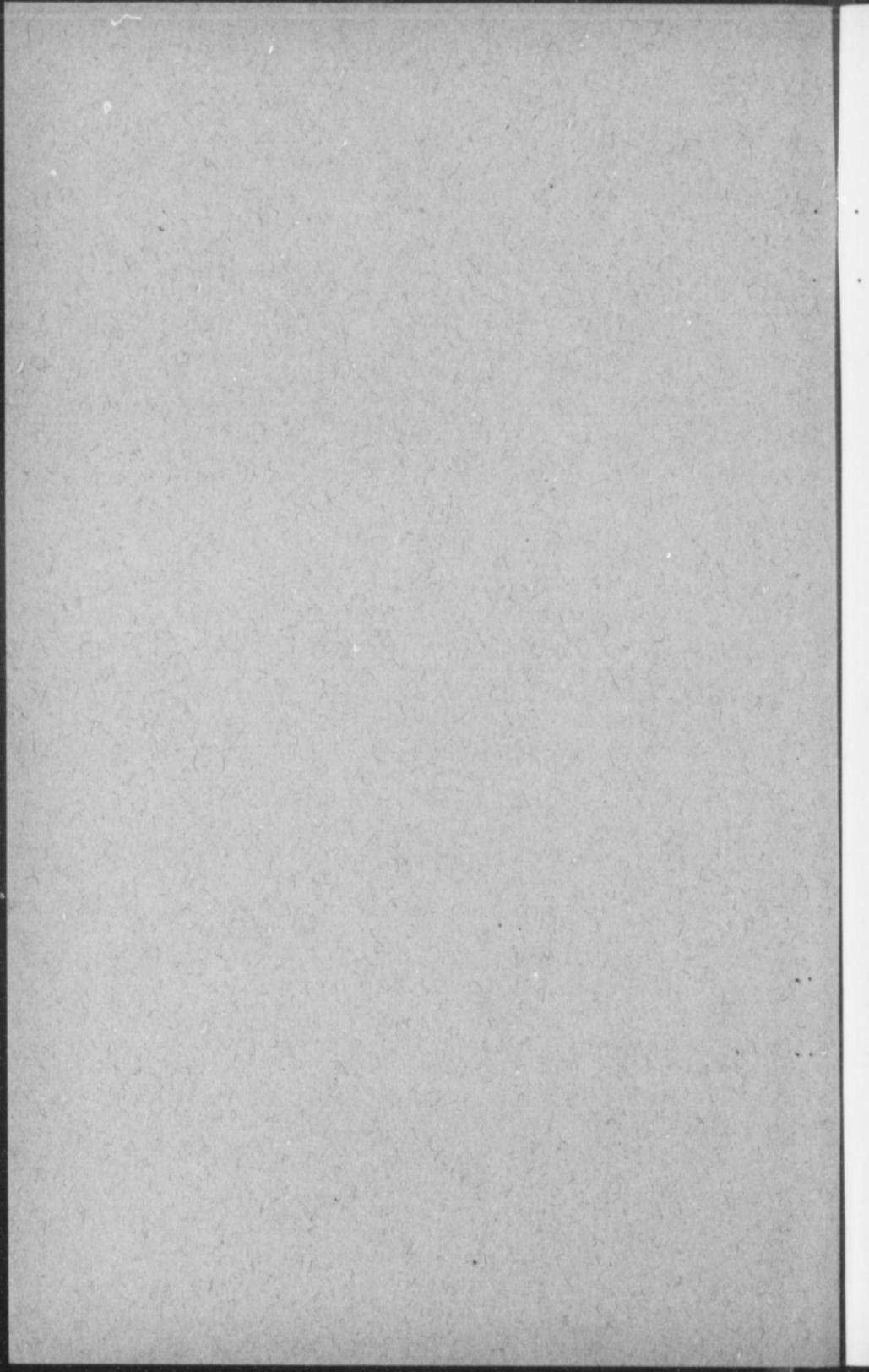
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## A MALIGNANT INTESTINAL GROWTH REQUIRING THE REMOVAL OF AN UNUSUAL NUMBER OF ABDOMINAL STRUCTURES

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My object in reporting this case to the society is to show what may be done in some cases in which the surgeon, on opening the abdomen, feels completely baffled, but in which, on carefully surveying the field, he finally detects the key to the situation, and can remove the growth that at first has seemed impossible of enucleation.

In this case my first impulse was to close the abdomen, but the family physician, Dr. Ira McCurdy, of Frederick, insisted that the patient had been suffering from excruciating abdominal pain, that there were already signs of partial obstruction, and that, judging from her condition for the past month, he felt sure she could not last over a few days without operation. Under these circumstances I made a further examination of the combined tumor, and found that the key to the situation consisted in first enucleating the uterus with the adnexa and turning them up on the tumor. The operation then became essentially an abdominal instead of an abdominopelvic one.

The after results certainly more than repaid us for the chances taken. The patient, after a short time, was completely relieved of her former pain, and in a few weeks was able to go about as usual. She had over a year of relatively good health before any further signs of the growth made themselves perceptible.

Mrs. M., aged fifty-six years, was seen in consultation with Dr. McCurdy, December 20, 1909. She was exceedingly thin, pale and emaciated. Before her illness, which dated back several months, she had weighed 120 pounds. At the time I saw her she weighed 85 pounds.

On pelvic examination I found what appeared to be a myomatous uterus, which was firmly plastered to the left side of the pelvis and which almost completely filled it. As the patient gave a history of having flattened stools, occasionally associated with diarrhea, we bore in mind the possibility of a malignant intestinal growth.

*Operation.* The patient was removed to the Johns Hopkins Hospital, where she was operated upon on December 28, 1909. On opening the abdomen we immediately found what appeared to be a mesenteric growth. Plastered over the surface were loops of small intestines and a considerable area of large bowel. The fundus of the uterus was firmly adherent to the tumor, and the appendix was also involved in the growth. Realizing the weak condition of the patient, and the extensive operation necessary to even attempt complete removal of the growth, I hesitated, but on being told by Dr. McCurdy that the patient could not live over a few days in her present condition, I accepted the responsibility and commenced the operation. After determining definitely that no secondary growths were visible, and finding that the original tumor was somewhat movable, and that it did not implicate the larger abdominal vessels, we started its removal. The key to the situation consisted in first freeing the uterus. I therefore did a supravaginal hysterectomy, taking away the uterus, tubes, and ovaries. No attempt was made, however, to separate the pelvic structures from the intestinal growth, but they were turned up on the surface of the tumor and the empty pelvis was then packed with gauze. The appendix was found intimately attached to the tumor mass. It was likewise cut off, covered with gauze to prevent infection, and turned up on the surface of the tumor;

the stump was then closed. We next encountered an adherent loop of small bowel near the cecum; to this a clamp was applied. The other end of the same loop, about 18 inches distant, was also clamped and the intervening bowel cut loose. The descending colon over an extent of several inches was intimately blended with the tumor. This area was freed. Finally, we were able, after using many catgut sutures, to tie off the mesentery which fastened the tumor to the vertebral column. The entire mass, consisting of the tumor, the descending colon, a large area of small bowel and several inches of large bowel, the uterus, tubes, ovaries, and appendix, was then removed in one piece. On carefully examining the small intestine we found that the blood supply for at least a foot and one-half had been injured; we therefore removed this area of bowel also.

The two ends of small bowel were closed and a lateral anastomosis made between the small bowel and the cecum, which was only an inch removed from the distal end of the small bowel. On the left side, where a considerable area of descending colon had been removed, the tissues were fortunately redundant. Here also we closed both ends and did a lateral anastomosis between the descending colon and the sigmoid. A drain was laid in the lower angle of the abdominal incision and another in the vagina.

The patient on her return to the ward showed a moderate degree of shock. After a week or two she had slight diarrhea, but otherwise manifested no untoward symptoms. At the end of five weeks she returned home in relatively good condition.

December 1, 1910. I heard from this patient a few days ago. She is in excellent health and is going everywhere. She has a good appetite and digestion.

March 20, 1911. The patient is rapidly losing weight, has a great deal of abdominal pain, and from the present indications will not survive over a month or six weeks.

*Description of the Tissues Removed.*

Path. No. 14,543. Examination of the hardened specimen: The specimen (Fig. 1) is made up of 15 cm. of the descending colon, containing a malignant growth, of between two and three feet of small bowel, of the uterus with its appendages, and the appendix, all in one mass.

The descending colon is occupied by a newgrowth, 8 cm. in length. This involves the entire circumference of the bowel, the walls varying from 5 mm. to 1 cm. or more in thickness. The bowel, where thickened, is in places smooth, but at other points presents an eaten-out appearance. The advancing margin of the growth is sharply defined and raised about 1 or 2 mm. from the surface. On the inner or median aspect of the growth there is a perforation. The growth has extended directly through and has communicated with a loop of small bowel. It has likewise encroached on the mesentery of the small bowel, forming a tumor, globular in shape and about 7 cm. in diameter. This has extended to the peritoneal surface of the mesentery, but does not appear to have broken through the surface. At one point, however, it forms a subperitoneal nodule 1 cm. in diameter. At the point where the fistula has extended from the colon into the small bowel, the walls have evidently become exceedingly thin and the right cornu of the uterus has become plastered on to the mesentery at that point (Fig. 2), evidently acting as a cork and preventing the broken-down area from bursting into the peritoneal cavity. The cornu of the uterus is firmly attached to the mesentery over an area 5 cm. in diameter.

The uterus itself is a little enlarged. The tubes and ovaries are normal.

The middle portion of the appendix is glued to the mesentery. The tip of the appendix is free, but the surface is in places covered with adhesions.

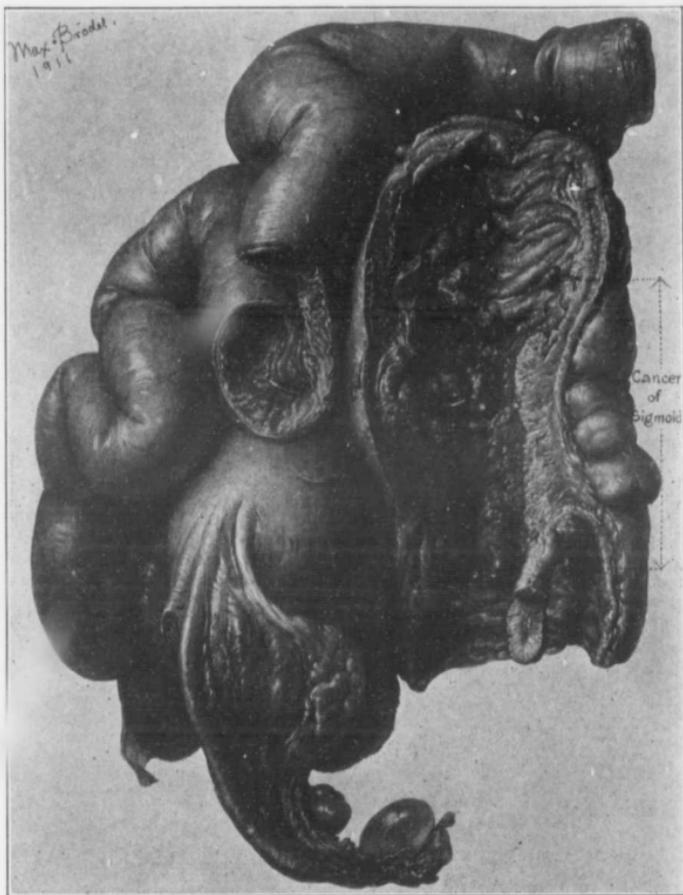


FIG. 1.—Removal of a carcimona of the sigmoid, several feet of small bowel, the uterus, tubes, and ovaries, and the appendix in one mass. The entire circumference of the sigmoid is involved by a carcinomatous growth. The advancing margin of the growth is sharply defined, and from the lower edge a long tongue-like polyp is growing. The cancer has eaten through the sigmoid and grafted itself upon the small bowel, and at one point had perforated the small bowel (as indicated by the bristle). Here there is a fistulous opening between the sigmoid and the lumen of the ileum.

Where the necrotic cancerous mass tended to break through into the general peritoneal cavity the uterus has adhered to it, thus eliminating the danger of peritonitis from this source. The normal tubes and ovaries are attached to the uterus. The appendix was involved in the process. It lies on the under surface of this mass. For the tumor on section, see Fig. 2.

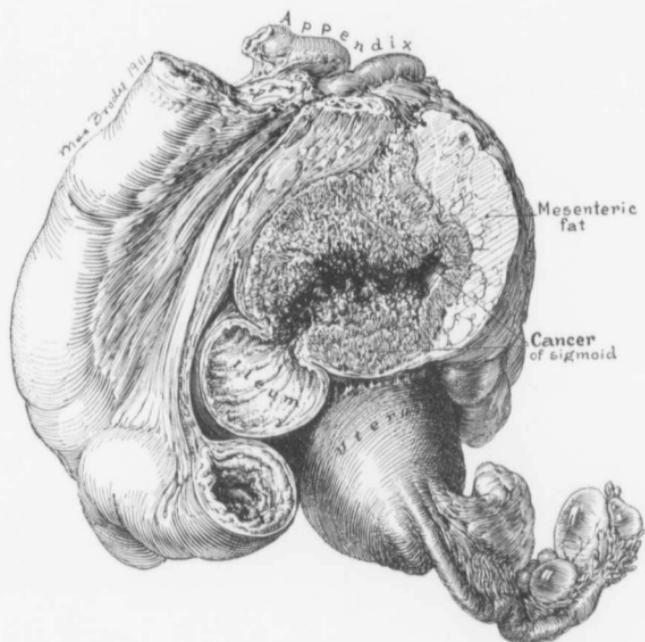


FIG. 2.—Carcinoma of the sigmoid breaking through into the ileum. This figure represents a transverse section through Fig. 1. The carcinoma occupies the entire circumference of the sigmoid at this level and has formed a fistulous opening into the ileum. The uterus has become intimately blended with the growth, reinforcing it at the point where it tended to rupture into the general peritoneal cavity. The adherent appendix is seen in the upper part of the specimen.

*Histological Examination.* Sections from the growth in the descending colon shows that it is an adenocarcinoma, the glandular type being very evident. The glands themselves, which, as a rule, are large, are lined with several layers of epithelium, and many of the glands contain secondary ones developing within them. The superficial portions of the growth have undergone necrosis. There is fragmentation of nuclei and coagulation necrosis. The uterus is the seat of a commencing adenomyoma. The appendix shows marked involvement.

In this case we have primarily a malignant growth of the descending colon. This has involved by continuity a loop of small bowel and opened into it. It has also formed a large tumor which has encroached on the mesentery of the small bowel. The fundus of the uterus has glued itself on to this malignant growth where the walls tended to give way.

