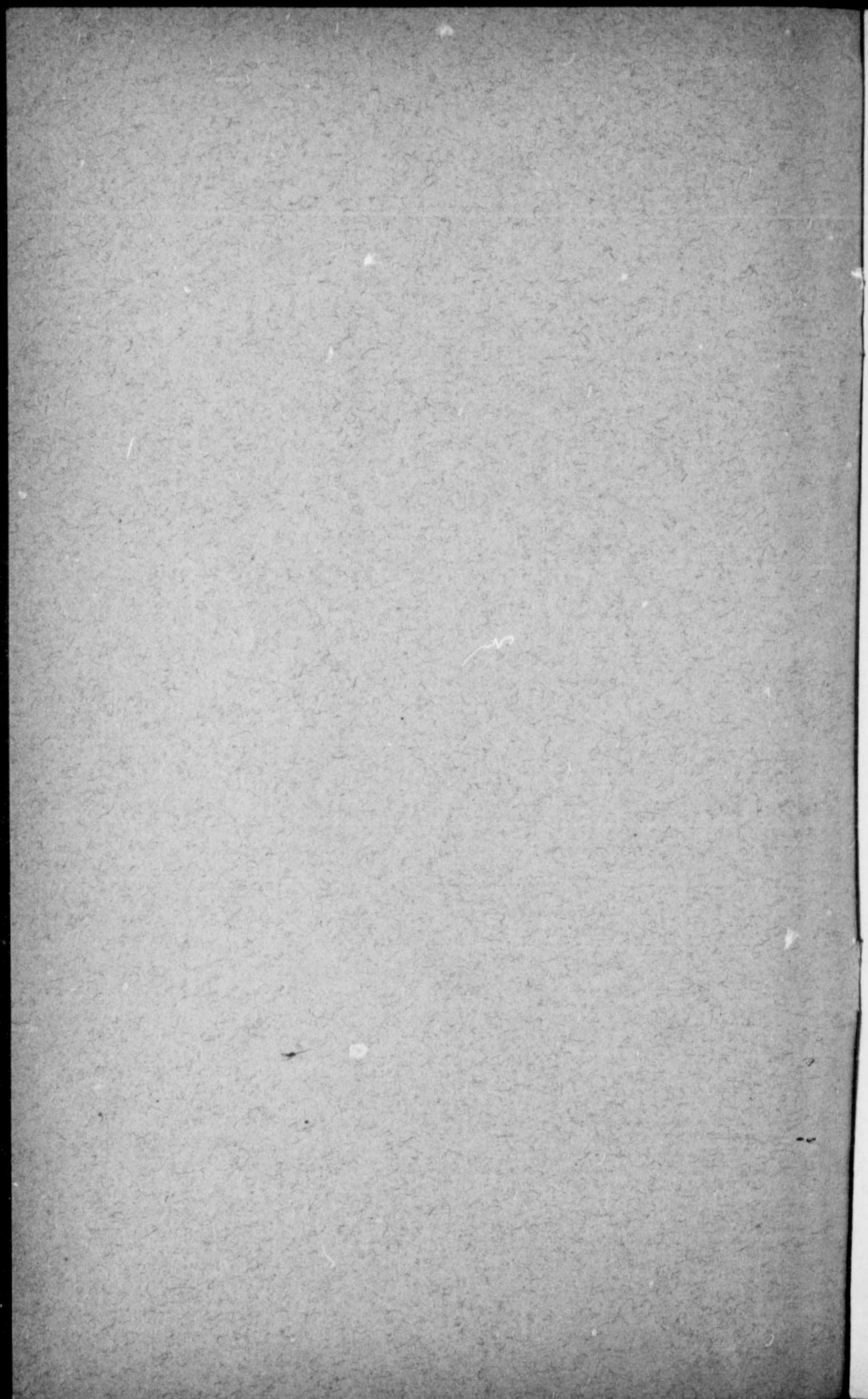
REPORT OF GYNECOLOGICAL CASES.

By Thomas S. Cullen, M. B.



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By Thomas S. Cullen, M. B.

This evening I wish to briefly report four rare cases of [89] uterine myomata which we have seen in the course of the last few months.

Case 1.—*A large myomatous uterus with a subperitoneal nodule molded to and filling the pelvis. Strangulated umbilical hernia. Removal of hernial sac. Hystero-myomectomy. Recovery.*

Mrs. F., seen in consultation with Dr. Shertzer on August 10, 1902. The patient had noticed an abdominal tumor for several years and had also complained of an umbilical hernia. The hernia came down occasionally but was reduced with ease. On August 11 it protruded and it was impossible to return it. When I saw her the pulse and temperature were perfectly normal but at the umbilicus there was a reddened area fully 5 cm. in diameter and surrounded by a zone of induration fully 15 cm. across. The tissues here were markedly œdematous and it looked as if the skin would soon become necrotic. On palpation a large mass could be felt filling almost the entire abdomen. Above it extended to a point midway between the umbilicus and zyphoid cartilage. On vaginal examination the entire pelvis was found to be filled with a hard myomatous mass. Immediate operation was advised. Fearing infection we completely isolated the indurated area around the umbilicus by stitching gauze over it. An elliptical incision was made, removing the entire indurated area. The sac was found to contain nothing but

[89] omentum. This, however, was deep red in color and would soon have become necrotic. The large tumor filling the abdomen and pelvis proved to be a myoma. The main tumor was liberated with little difficulty, but projecting from the posterior surface of the myoma was a large secondary myomatous growth which filled the pelvis completely and was molded to the pelvis. It was impossible to liberate this growth until the uterus had been completely freed from its cervical attachment. The patient made an uninterrupted recovery. When I saw her on November 3 she was in excellent health.

This specimen is particularly interesting from the subperitoneal myoma conforming so definitely to the outline of the pelvis.

CASE 2.—*Myomatous uterus, very large pedunculated submucous myoma filling vagina, also with a large subperitoneal nodule adherent to the right ureter and blood-vessels at the pelvic brim. Complete hysteromyomectomy with great difficulty in delivering the submucous myoma per abdomen. Accidental temporary ligation of the right ureter. Recovery.*

Miss R., seen in consultation with Dr. F. Gavin on October 24. The patient was 46 years of age. She menstruated at 13 and has always been regular. For the last five years the [90] menstrual periods have been prolonged and profuse and there has been some leucorrhœa. About this time she felt a small nodule the size of a walnut in the lower abdomen. At present she is very anæmic, constipation which has always troubled her has been more severe during the last year and for three years there has been frequently painful micturition. On abdominal examination distinct bosses can be felt rising to the pelvic brim and on vaginal examination a large mass, the exact dimensions of which cannot be determined, fills the vagina. This mass appears to be about the size of a cocoanut.

Operation October 25: A median abdominal incision was made, extending almost from the umbilicus to the pubes. A myomatous uterus was found. The greater part of the

mass extended below the cervix. The left tube and ovary [90] were tied off and then the round ligament secured. The right side was treated in the same manner but here a subperitoneal myoma about 5 cm. in length and irregular in outline was found. This lay along the course of the iliac vessels and was intimately adherent over the site of the ureter. Its attachment to the uterus was by a muscular pedicle 5 mm. in thickness. We severed this subperitoneal myoma from the uterus and left it *in situ* as its removal at this stage of the operation was impossible. The uterus was drawn still further upward, the bladder was pushed down until the vagina was exposed. The vagina anteriorly was drawn up between two pairs of artery forceps and cut between. Once in the vagina, which by the way was greatly drawn out and distended by the submucous myoma, we were enabled to cut under sight from before backward and in a short time had the uterus and the vaginal cuff entirely free. On making traction, however, it was impossible to dislodge the submucous myoma which filled up the entire vagina and was attached to the uterus by a pedicle fully 2.5 cm. in diameter, but after making gentle but steady traction and pressing downward upon the bladder the myoma was dislodged with a loud sucking sound. Had we not been able to liberate it in this way we should certainly have applied obstetrical forceps. Attention was now turned to the myoma in the right side and to the right tube and ovary. The peritoneum over the myoma was split, and the myoma pealed out as gently as possible. In the meantime, however, we found it necessary to control the right ovarian vessels. This was somewhat difficult. After removing the myoma we examined the right ureter and found it included in the stump with the ovarian vessels. The vessels were picked up, the previous sutures cut and the ureter liberated. The raw surfaces on the vaginal margin were controlled with catgut and the opening in the vaginal vault narrowed down until it was about 2.5 cm. in breadth. A gauze drain was laid up to the brim of the pelvis on the right side to catch any urine should extravasation take place from the previously constricted

[90] ureter. This gauze of course was covered over with peritoneum and was accordingly extraperitoneal. Another piece of gauze was dropped down into Douglas's sac as a safeguard should there be any slight sepsis, as it was impossible to thoroughly cleanse the vagina prior to operation. The patient stood the operation well.[1]

In this case one naturally asks why was not the large submucous myoma removed per vaginam prior to the hysterectomy? In the first place, the patient was an unmarried woman and removal in such a manner was almost out of the question without first making a deep incision in the vaginal wall. In the second place the bleeding was so free during the slightest manipulation that we hesitated to give the necessary cleaning.

The situation of the ureter in this case was of especial interest as it was far out of position and right up beside the ovarian vessels. We only had a narrow chink of about 8 mm. in breadth in which to tie the ovarian vessels and it was impossible to control them in any other situation.

CASE 3.—*A partially parasitic myoma receiving its blood supply chiefly from the enlarged omental vessels and a densely adherent bladder. Also associated with over 50 litres of ascitic fluid and clinically presenting the typical picture of a patient suffering from a tremendous ovarian cyst. Removal of parasitic myoma. Recovery.*

Miss P., referred to me October, 1902, by Dr. Hopkins. The patient is 54 years of age, very thin and has the typical expression of one suffering from an ovarian cyst. For several years she has been complaining of abdominal distension. The abdomen is greatly enlarged, and in the lower portion near the pubes there is much œdema. There is, however, little or no swelling of the extremities. The entire abdomen is dull on percussion but in the flanks there is some tympany. On palpation a slight wave of fluctuation can be elicited. I saw this patient several days ago but on account

[1] The patient left the hospital November 29, 1902, feeling perfectly well.

of a recent bronchitis operation was deferred. We, however, thought it advisable to tap, and over 39 litres of clear straw-colored fluid were removed. [90]

Operation October 29: On opening the abdomen we obtained at least 15 litres more of free fluid, the peritoneum was thickened, the intestines were of the normal color and lying immediately beneath the incision was a globular tumor at least 16 cm. in diameter. Above the omentum was practically missing but the omental vessels had become greatly enlarged and had grown into the posterior surface of the tumor. These vessels had exceedingly delicate walls and were surrounded by little connective tissue. So friable were they that the slightest traction was sufficient to rupture arteries at least 3 or 4 mm. in diameter. The omental vessels were tied off and the tumor delivered. It proved to be a subperitoneal myoma which had become partly parasitic. It was attached to a practically normal uterus by a pedicle 4 cm. broad and 1 cm. thick. It was densely adherent to the parietal wall of the left side and anteriorly was intimately attached to the bladder from which it had received an abundant blood supply. In order to release the bladder it was necessary to sever the pedicle of the myoma and to turn it downward over the symphysis, making the point of cleavage on the posterior surface. Much bleeding took place but was [91] readily controlled. The stump at the fundus was turned in by catgut sutures. The patient made an uninterrupted recovery.

In this case we had the typical facial expression of a patient suffering from an ovarian cyst. Furthermore, we found dulness in front as we would naturally expect with a multilocular cyst and also noted tympany in the flanks. In the first place the dulness was undoubtedly due in part to the omental vessels and the myoma together, forming a barrier to the intestines floating upward, and in the second place the distension was so great that the mesentery was not long enough to allow the intestines to reach the surface. The fact that the intestines were held back naturally accounts for the tympany in the flanks. The association of as-

[91] citic fluid with the presence of uterine myomata is most exceptional. In this case it was probably due to the twisting of the omental vessels by the freely movable myomatous growth.

Case 4.—*Removal of a large interstitial and partly submucous myoma. Subsequent sloughing of inner layers of uterine walls removal of necrotic tissue followed by recovery.*

The patient, who was 38 years of age, was admitted to the Hebrew Hospital on July 14, 1902. She had noted a pelvic tumor for some years, but it gave her little concern until pressure symptoms manifested themselves and she came complaining of swollen legs which were dark purple in color. The urine showed a considerable quantity of albumin. We removed a large interstitial and partially submucous myoma nearly the size of an adult head. The uterine cavity was opened in several places. After operation she did well for several days, then her temperature rose two or three degrees and she had some headache and much nausea. The urine contained quantities of epithelial and blood casts. At the end of fifteen days there was a most offensive vaginal discharge. We examined under anæsthesia and found pus oozing from the cervix. The posterior lip of the cervix was then split to obtain free drainage and we removed fully a large handful of necrotic tissue from the interior of the uterus. Its removal did not occasion any hæmorrhage and the necrotic material was evidently sloughing uterine tissue. In this case we had stitched the uterus to the anterior abdominal wall. Consequently the line of incision was protected. Otherwise we would undoubtedly have had separation of the muscular walls with escape of purulent material into the abdominal cavity. The necrotic process apparently occupied both the anterior and posterior walls.

This is a most rare complication and the first that we have seen.

I saw this patient a few days ago and she is in good health.