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Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

NOTTINGHAM GENERAL HOSPITAL.

GASTROTOMY: REMOVAL OF FIBROUS TUMOUR OF UTERUS: DEATH.

By JOHN SLOANE, M.D., House-Surgeon to the Leicester Infirmary, etc.

[Read before the Leicester Medical Society, February 2nd, 1858.]

THE notes of the following case I took when I was assistant resident surgeon in the Nottingham General Hospital; and Mr. Eddison at the time kindly gave me permission to publish them.

Eliza Brownlow, aged 33, was admitted into the General Hospital, Nottingham, on October 3rd, 1854, under the care of Mr. Eddison. She works in a lace-warehouse; is unmarried; of healthy parentage and temperate habits. From the age of four to twenty-five years, she was much troubled with strumous disease in the glands of the neck, which is much scarred on both sides. With this exception, she enjoyed good health till 1849, when she began to experience in the left iliac region a severe pain, which would last for about a week, and from which she would probably then be free for about a month. The length of the intermissions has gradually decreased, and now she is released from suffering for only a few days, and the pain continues for about three weeks. In 1851, Mr. Eddison detected a tumour, which he believed to be ovarian, low down on the left side of the abdomen; it has since gradually increased. In this year, she informs me, she was in the Hospital for Diseases of Women, in Soho Square, London, for six weeks. Her medical attendants there suspected pregnancy, and advised that no very active treatment should be adopted till that point was decided. In 1852, she had an attack of peritonitis, and again in 1853; these attacks yielded under Mr. Eddison's treatment. During the last two years, fluid has been collecting in her abdomen, which has given rise to the usual symptoms. Four days after admission, Mr. Eddison tapped her, and drew off seven pints of serum. This he did in the usual site, by cutting through the parietes as far as the peritoneum with the lancet, and then perforating this membrane with a female catheter, through which the fluid escaped. This operation, as usual, has afforded much relief.

October 11th. She complains of the pain previously described. The appetite is bad; there is some pain after eating or drinking, which generally lasts about half an hour. She has been subject to sickness and vomiting for about the last six months, but has not been sick for the last two days. The bowels are gently relaxed without medicine. On an endeavour being made to ascertain the extent of hepatic dulness, she complained so much that the percussion caused pain, that I was obliged to desist. Some tenderness on pressure existed all over the abdomen, which is enlarged generally. A large solid tumour can be felt, which seems to fill the whole of the lower part of the abdominal cavity. The menses are regular; she has slight leucorrhœa. There is no œdema of any part. Pulse 112; very feeble. The urine is scanty, and has a specific gravity of 1013; in other respects it is normal. The other organs appear to be healthy.

The tumour was believed to be ovarian; and, after two consultations of the surgeons of the Hospital, it was decided to remove it. The patient herself was very anxious to have the

operation performed, after she was made acquainted with the dangers she incurred.

Her ward, which contained only two beds, one of which was not occupied, was heated to 70° Fahr.; and this degree of temperature was kept up for two days. At 11 A.M., she was removed to an operating-table, placed at her bedside, and, while she was under the influence of chloroform, an incision was made in the mesial line from the umbilicus to the pubes. A considerable quantity of serum escaped, and there was rather profuse hæmorrhage. Some old and firm adhesions between the tumour and the abdominal wall were broken up, and several cysts containing serum in the diseased mass were opened to lessen its size, before it could be extracted. The peduncle, nearly circular, was about one inch and a half in diameter. It was perforated by a needle carrying strong whipcord, which was divided, and the four ends were tightly tied. It was then divided between the ligature and the tumour, close to the latter. The edges of the incision in the abdominal walls were drawn together by interrupted suture; compresses were applied; and pressure was kept up by a very broad flannel bandage. During the progress of the operation, constant pressure was made on the abdomen by an assistant; yet she appeared to be on the very verge of syncope. After being placed in bed, she gradually rallied for some time, but still continued in a very depressed state. Bottles of hot water were applied to her extremities; and some brandy, beef-tea, etc., were cautiously but assiduously administered. She died about 4 o'clock, five hours after the commencement of the operation.

On dissection seventeen hours after death, very little serum was found in the abdomen, and no blood. There was diffused florid redness of the peritoneum anteriorly. This membrane was lacerated extensively in several places, where adhesions had existed; and the fold reflected from the uterus to the rectum was torn. The divided peduncle was attached to the fundus of the uterus. The ovaries were not enlarged; they were corrugated, and the left contained several small cysts. In the left pleura were found about two pints of clear serum, with the left lung floating upon it; there were no pleural adhesions. The tumour, after several cysts near its surface had been punctured, weighed fifty ounces. It was solid and hard. In shape and size, it much resembled an adult human brain.

Mr. Paget, of St. Bartholomew's Hospital, to whom half of the tumour was presented, examined it, and reported upon it as follows:—

"The tumour, of which I have received a portion to-day, appears to be good example of the fibrous tumour of the uterus. It has all the obvious characters of structure belonging to such tumour; and with the microscope one finds in it abundant small smooth muscular fibres and tough fibrous connective tissue. It includes a certain number of cysts, as if in progress towards the characters of the fibro-cystic tumour. A thin layer of substance is separable from parts of the outer surface of the tumour, which I suppose is the peritoneum, and the outer layer of the wall of the uterus, which it has extended in its growth. Beneath this layer also there appears to have been large spaces, which I presume were cysts."

REMARKS. In connexion with a case of ovarian tumour which came under my notice in the Leicester Infirmary, and which was reported in last week's JOURNAL, this case of fibrous uterine tumour will serve to impress upon us the impossibility in all instances of distinguishing between these two diseases. The similarity between the two cases is increased by the fact that, in the progress of each, before any operation was resorted to, there were vomiting and repeated attacks of peritonitis. The symptoms of fibrous tumours of the uterus, whether attached to the interior or to the exterior surface, are, menorrhagia, which generally is present, especially when the growth occupies the interior of the womb; retention, or a frequent desire to pass urine; and variable sensations of pain in the lower part of the abdomen. The last was the only symptom present in this case; whereas the first mentioned, which is the most important, had not

occurred. When the tumour was first observed, it was situated low down on the left side, indicating an ovarian origin. But fibrous uterine tumours are seldom mesial; so that position does not assist much in forming a diagnosis; neither does the desire and inability to pass urine, as this symptom is also observed in cases of ovarian tumour. Indeed, various sensations of pain in the lower part of the abdomen are frequent concomitants of ovarian tumour; and, in this disease, menorrhagia is by no means very rare; so that every symptom of uterine fibrous outgrowth may be observed in cases of ovarian tumour; and the converse. According to the observations of Dr. West and Mr. Lee, in more than one-third of the cases, fibrous tumours are situated on the posterior wall of the uterus, causing more or less displacement of the os backwards; and, when the tumour is situated on the anterior wall, the os is of course displaced in the contrary direction; but in this instance, as the growth was attached to the fundus, the uterus occupied its usual position. The slow growth of the tumour certainly indicated a uterine origin; but it appears to me that the bulk of the evidence most accorded with the view that it was ovarian. Immediately before proceeding to perform ovariectomy in cases where a doubt exists as to the nature of the growth, it would be advisable to make a small incision through the abdominal walls, in order to ascertain the colour of the tumour; as, if it be bluish white, it is ovarian; whereas, if it be red, it is probably uterine. If a correct diagnosis had been formed in this case, I do not believe that the operation would have been resorted to; inasmuch as, in the few cases on record in which fibrous outgrowths of the uterus have been removed by gastrotomy, all, except one reported by Atlee, an American, have ended fatally. Besides, these tumours do not tend, as a rule, rapidly to destroy life; and this patient was not exposed to two of the causes which induce a fatal result in this disease. Not being married, she was not likely to become pregnant; and she did not suffer from menorrhagia; but, from the occurrence of ascites, it is not probable that she would have survived long.

If the tumour had been ovarian, was ovariectomy advisable in this case? The profession is divided into two parties on this question. One party holds that the operation is so very frequently fatal, that it is never justifiable; the other contends that, in properly selected cases, the operation is not only justifiable, but advisable. In my humble opinion, the position of the latter is best supported by facts. Dr. Clay of Manchester, who has had greater experience in this operation than any other man, last summer had performed it in seventy-nine cases, fifty-five of which had been successful; but he believes that, with his increased experience, he will not in future lose more than 25 per cent. He has operated on patients as young as twelve, and as old as fifty-eight years; but he would not operate in a patient beyond fifty-eight. He seldom has removed a tumour weighing less than twenty-five pounds; and he has removed as much as seventy-three pounds at one time; but tumours, varying from thirty-five to forty pounds in weight, have been the most common. He prefers a case without adhesions; but he thinks lightly of them, and does not hesitate to operate in cases otherwise favourable. Where they exist, when the adhesions are recent, he detaches them; if firm, he cuts the band near to the tumour, leaving a portion attached to the peritoneal surface. He has often, however, cut away large portions of the peritoneum without bad results; and he does not fear to sponge out the abdominal cavity. He invariably adopts the large incision. According to his statements, most cases of ovarian tumour will be suitable for this operation. The only objection he mentions is, the patient being above fifty-eight years of age; but I presume he would not operate where the patient was very feeble, or suffered from a formidable disease in some other organ. He states that ovarian tumours "seldom exceed two years without completing their termination some way"; but I have myself met with cases, in which large tumours of the ovary had existed for a long series of years, and were a source of annoyance, chiefly from their weight, and the effects of pressure. Some, I know, run a very rapid course; and, according to Professor Simpson, they may even lead to a fatal result within a year. Cazeaux states that their duration is variable, the average being about four years; whereas Velpeau believes the average to be six, ten, or twelve years; and, according to Huguier, the younger the patient, the more speedily does she sink under the disease. It appears to me that, in an affection in which the natural tendency to recovery is so very slight, and in which the progress to a fatal result is so certain, and in some cases so rapid, we should be culpable unless we resorted to the means

available to science to control or to cure the disease. Ovariectomy is the only remedial measure to which we can resort, with the hope of success, in the cases of multilocular tumour, which are much the most common. But some surgeons under no circumstances will perform this operation. Velpeau states "that extirpation of the ovaries is a fearful operation, and ought to be proscribed, even were the cases which have been announced real." This opinion, I have reason to know, is extensively held by surgeons in our own country. I was told last year by Mr. Hutchinson, of the Metropolitan Free Hospital, that, in three years, reports of about a dozen cases of ovariectomy performed by hospital surgeons had been sent to him; and they every one had ended fatally. Moreover, as far as he knew, the details of not more than one or two of these cases had been published. Dr. Clay's success is extraordinary, and is not approached, I believe, by that of any other practitioner. His plan of operating, and the treatment he adopts subsequently, have been published; and, if carefully followed by other surgeons, one can see no good reason why the results, in other hands, should be so very unfavourable, compared to his.

Tapping is, at the best, only a palliative measure, and is, as you all know, generally had recourse to when urgent dyspnoea is caused by the large mass in the abdomen. It affords information respecting the nature of the tumour, whether it is unilocular or otherwise. If believed to be unilocular after the tapping, the cyst may be dragged through a small incision in the abdominal parietes, and a ligature placed on the pedicle. For this less formidable mode of extirpating an ovarian tumour to prove successful, it is essential that the cyst should be unilocular, which is rare; and that there should be no adhesions, which, according to Clay, is still more rare. In unilocular ovarian tumours, where adhesions do exist after tapping, we may inject the sac with tincture of iodine. This plan of treatment has been employed of late a good deal in this country, and by none, I believe, more frequently than by Professor Simpson. He has adopted this treatment, he states, in twenty or thirty cases; sometimes with complete success, the sac not again becoming filled, and the patient remaining well and strong; in other cases, the tumour continues present, but has not increased to any great size. In some of the patients, the largest cyst in a multilocular tumour had become obliterated, but the smaller cysts had continued to enlarge; in others, the treatment had failed, inasmuch as the cyst had again filled. In one case only had death resulted; and he attributed the death in this instance rather to the paracentesis than to the injection. The iodine injection, in his hands, has been seldom attended with much pain, or with very severe local or constitutional irritation; but, in the practice of others, the injection has been sometimes followed by unconsciousness which has lasted as many as fifteen hours, and by vomiting which has continued for several days; yet, notwithstanding these grave symptoms, the patients have afterwards done well. A few cases are recorded in which death followed the operation, but in most of these the cavity of the abdomen had received the injection, instead of the ovarian cyst. To prevent the risk of this serious mishap, Mr. Hutchinson recommends a flexible catheter to be passed to pretty nearly its whole length through the canula into the sac before more than half the fluid has escaped, and that the iodine should be injected through the catheter after all the fluid has drained off.

Rather more than a year ago, the treatment of these tumours underwent a lengthened discussion at the Academy of Medicine in France, and the following are some of the propositions deduced from the statements of the speakers by M. Saurel:—"The proceeding to which it is advisable, in almost every case of ovarian cyst, to have recourse, is puncture, followed by ioduretted injection, with occlusion of the opening.

"Unilocular cysts, without organic alterations of their walls, containing a serous or sero-sanguinolent or albuminous fluid, cysts which have originated in an extra-uterine pregnancy, and purulent cysts, are most amenable to treatment.

"The proper time to operate is when the cyst, not having yet acquired a large size, is beginning to cause suffering to the patient, or to exercise an injurious reaction upon the functions."

The only form of ovarian tumour which undergoes, and that very rarely, a spontaneous cure, is that composed of a single cyst. This sometimes ruptures, and discharges itself into the peritoneum, or into some viscus with an external outlet. The fluid in the cyst has sometimes become absorbed, and the cavity obliterated.