In the recent case which I have just quoted, in which the embolus moved on into a smaller branch, finger pulsation was afterwards easily elicited in the arteries on the disc.

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MYOMECTOMY DURING PREGNANCY.*

BY

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In this very short review, for which are taken as a basis cases observed in the Clinique d'Obstétrique et de Gynécologie de la Faculté de Médecine de Paris (Professor Brindeau) during the last four years, I will confine my observations to the indications and operative technique of myomectomy during pregnancy.

Primarily, let it be understood that judgement and common sense are required in the selection of each case for myomectomy during a pregnancy. As regards the indications for myomectomy in cases complicated by the presence of a fibroid or a myoma, it is only very exceptionally that operation during pregnancy is the correct procedure, because usually these tumours, while they may give rise to difficulty during the actual labour, seldom cause trouble during the pregnancy. Moreover, if it is remembered that the scar left by the operation may be the site of a rupture of the uterus during labour (and such cases are on record), it will be agreed that this procedure is to be avoided if at all possible. However, we are bound to admit that myomectomy is indicated in certain cases, these being as follows.

1. When the fibroid is large and is diagnosed early during the pregnancy, before the third month, and when the swelling of the tumour is easily distinguishable from that of the uterus. By performing myomectomy at this time all possibility of complications is avoided, during both the pregnancy and the labour.

2. At any time during the pregnancy when unmistakable signs of necrobiosis of the fibroid appear. Necrobiosis is indicated by the tumour becoming acutely painful and frequently softer in consistency. This is often preceded by hypertrophy of the fibroid, and at the same time there are signs of peritoneal reaction, such as vomiting, abdominal rigidity, and a weak pulse.

3. When, owing to the presence of a fibroid, there is an axial torsion of the uterus or a partial retroversion causing a kink in its longitudinal axis and threatening to bring about the termination of the pregnancy.

4. When there is torsion of the pedicle of the tumour, the symptoms of this occurrence being severe and lasting pain accompanied by the symptoms of peritoneal reaction mentioned above.

5. When the fibroid causes pressure on the neighbouring organs, the chief of these being the bowel (occlusion), the ureter (hydronephrosis, pyelonephritis, or anuria), the urethra (retention of urine), and the veins in the pelvis, causing oedema or thrombo-phlebitis.

With the exception of the foregoing there are no indications to justify a myomectomy during a pregnancy, although it is admitted that such an operation may be successful in other cases.

As for the operative technique, the main points for consideration are as follows.

1. General anaesthesia is preferable to spinal anaesthesia, the reason being that in the latter the contractions of the womb are not suppressed, and are even exaggerated.

2. The tumour should be decapsulated by a single incision running over its summit, and not removed by a circular incision around its base. This allows of easier decapsulation of the tumour, and also of easier closing of the peritoneum afterwards.

3. All bleeding must be carefully stopped. The best method to employ is to understitch the bleeding point with thick catgut; this must be tied loosely to avoid cutting through the tissue.

4. In cases where the fibroid is between the layers of the broad ligament an attempt should be made to approach the tumour by the transligamentous route, incising the anterior or the posterior leaf. Care must be taken to avoid the uterine vessels and the ureter while doing this.

5. No drainage should be employed.

6. Morphine should be given in large doses during the three days following operation; I give 1/6 grain every six hours.

Following these principles the following results have been obtained during a period of six years (1920-26).

Total myomectomies performed during pregnancy	52
Number of myomectomies followed by abortion...	4
Number of myomectomies followed by premature labour	4
Number of cases going to full term	41
Maternal mortality	1
Cases not seen again after leaving hospital	2
Infantile mortality, including abortions	7
Average maternal mortality	1.9%
Average infantile mortality	13%

Since January 1st, 1924, we have operated on 21 women, not only during pregnancy, but also during labour and the puerperium. In 8 of these patients we were able to perform a myomectomy: 3 before term (1 after abortion), 2 after full term, and 3 during the puerperium. In 7 cases a living child was obtained. Hysterectomy was performed in 13 cases, as follows: 1 vaginal, after abortion; 6 without Caesarean section (1 two months pregnant, 1 three months pregnant, 1 six months pregnant, and 3 during the puerperium); 6 after Caesarean section. In 9 cases living children were obtained.

These statistics show that out of 21 cases we were only obliged to operate five times during pregnancy, twice after abortion, eight times at full term, and six times during the puerperium. In other words, in 38 per cent. of the cases myomectomy was employed, and in 62 per cent. of the cases we were obliged to perform hysterectomy.

Thus it should be borne in mind that if operation is undertaken during pregnancy it is necessary in 62 per cent. of cases to perform hysterectomy; operative intervention during pregnancy should, therefore, be postponed as long as possible in order to obtain a living child.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

ABDOMINAL ANEURYSM: DEATH SEVENTEEN YEARS AND SEVEN MONTHS AFTER OPERATION.

At the Annual Meeting of the British Medical Association held in Birmingham in 1911 I reported a case of abdominal aneurysm which had been treated the previous year by the introduction of a Colt's cage of 150 inches of wire. At the time of operation there was a large saccular aneurysm in the region of the coeliac axis. The patient had been under careful medical treatment for eight months previously. A few days after operation the aneurysm commenced to harden. Eleven months later an abdominal aneurysm could still be recognized from continued pulsations and a persistent murmur below the tumour, but all pain and discomfort had disappeared and he resumed work without inconvenience. Later still the murmur disappeared, as did all trace of expansile pulsation. To the end a hard mass could be felt with transmitted pulsations from the aorta. There was a history of syphilis and for the last few years the man showed signs and symptoms of locomotor ataxia in a very chronic form.

On March 29th last the assistant medical officer of Guinness's brewery was called to see him. He complained of pain in the right lumbar region and lower abdomen. Examination revealed nothing of significance. The site of the aneurysm (in the upper left quadrant) was not

* A paper read in the Section of Obstetrics and Gynaecology at the Annual Meeting of the British Medical Association at Cardiff, 1928.