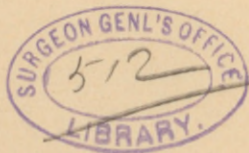


Krug (Fr.)

Hysterectomy in Ectopic Gestation with
Disease of the other Appendages.

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HYSTERECTOMY IN ECTOPIC GESTATION WITH DISEASE OF THE OTHER APPENDAGES.*

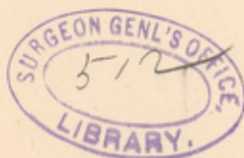
BY FLORIAN KRUG, M. D.

The subject of hysterectomy in bilateral disease of the uterine appendages was fully and ably discussed before this society in the fall of last year. It is not my desire to go over the whole ground again and start a discussion on the general topic, although I may say that it is a matter of great gratification to myself and, no doubt, to every advocate of the new procedure to record within a short space of time so many converts to a method which, at first, met with such adverse criticism and, at best, was given a very lukewarm reception.

I intend to confine myself to-night to a special indication for suprapubic ablation of the uterus and would ask you to restrict your remarks to the limits of this particular subject, so as to have it discussed in all its aspects. While I realize that I shall not meet with the approval of all of you in this procedure, which at a first furtive glance may appear as too radical, I feel sure that I have been working in the right direction. This conviction, together with the confidence obtained through most happy results in carrying it out, gives me the assurance to bring this subject before you. There is but one true conservatism in surgery—the one that preserves health and life.

I deem it best to give the histories of the four cases operated upon by me this winter, omitting all unnecessary details. As I go along relating them, I shall endeavor to convey to you the line of thought which forced me to consider this way of dealing with such cases the safest and most rational of all. They have all been operated upon during my recent service at the German Hospital, and I may add right here that every one of them made an absolutely smooth and perfect recovery.

* Read before the New York Obstetrical Society, April 17, 1894.



CASE I.—When I took charge of the service on October 15, 1893, I found a patient, aged twenty years, married since February of the same year, in a very precarious condition. She had been admitted on the previous day. Her temperature was 101° in the morning and ran up to 103.5° in the afternoon. The entire abdomen, extremely tender, highly tympanitic, can not stand the slightest touch. The patient is partly delirious and vomits constantly; pulse 126 to 140. *Per vaginam*, a doughy and semi-fluctuating mass is made out, filling the entire pelvis and bulging out in the posterior fornix. The patient not being able to give an account of herself it was learned from her relatives, and afterward confirmed by herself, that she had gone over her time for seven or eight weeks, when in July she was seized with violent pains and had a severe hæmorrhage which was taken for a miscarriage. No fœtal structures, however, were found. She has been in bed ever since and has not been without pain and metrorrhagia for one day. Without going into details in giving you my reasons, I will state that I at once entertained a strong suspicion of extra-uterine pregnancy, with partial rupture of the sac and formation of a hæmatocele, which had suppurated and caused the existing peritonitis. Having frequently met with this complex set of symptoms, and having afterward confirmed the diagnosis on the operating table and by the aid of the microscope, I felt that in this case also I was coming as near as possible to the correct diagnosis, although I was not positive. Considering the extremely critical condition of the patient, I did not think it justifiable to adopt radical measures at once. My object was to combat first the immediate danger to life and, giving her a chance to recuperate from the severe septic infection, to proceed with the ultimate radical operation at a later and more favorable time. On the 17th of October the patient was anæsthetized. There being a nasty, purulent discharge from the uterus, I considered it imperative, first to sterilize the uterine cavity. A sharp curette brought away a quantity of broken-down blood-clots and thoroughly diseased endometrium. Irrigation and tamponade of the cavity were practiced. A free incision was then made into the exudate in Douglas's pouch and about a pint of foul-smelling, discolored blood came away. On inserting the finger, I found a very large cavity containing a great amount of discolored blood-clots which were removed by gentle manipulation and irrigation, and the cavity was packed with gauze. The change in the patient's condition was very apparent. Within a few days the tympanitis subsided, the temperature became near to normal, the pulse below 100, the cavity was found smaller with every dressing and the

patient rapidly gained in strength. Four weeks afterward I considered it safe to undertake the radical operation, which was performed on November 20, 1893. The cavity and the vagina having been thoroughly cleansed, the abdomen was opened in the median line. Dense adhesions between all the viscera were found. Having separated them, the appendages could not be made out distinctly; everything appeared as one mass, in which the uterus was impacted. Taking care to avoid the ureters, the entire mass was removed. Very little hæmorrhage occurred. The pelvis was packed with iodoform gauze, after the stumps had been inverted into the vaginal opening. The abdominal wound was closed. The highest temperature after the operation was 100.8° ; recovery was without an untoward symptom, and the patient was discharged December 13, 1893.

Owing to the septic changes in the sac, it was impossible to prove the existence of chorionic villi. The case, therefore, is open to doubt, whether it really was an extra-uterine pregnancy; still, I am convinced that so-called hæmatocele in ninety-nine out of one hundred cases is the result of a ruptured extra-uterine pregnancy and, considering the history of the patient, I think in this case it ought to be classified as such.

CASE II.—On November 29, 1893, a patient, aged twenty-six years, was admitted to the German Hospital, with quite an interesting history. In January, 1891, she had been brought to the same hospital in an ambulance, in a deep state of collapse. Shortly before she had been dismissed from one of our city hospitals. Later on it was learned that she had had one child, that she had menstruated several times afterward, then went over her time, and applied for medical advice on account of severe pains in her back and side. The family physician found a tumor posterior and to the left side of the uterus, made the probable diagnosis of a pyosalpinx and referred her to the aforesaid hospital for operative treatment. A trachelorrhaphy was performed there. The silver-wire sutures still being *in situ*, the patient was discharged and it was soon after that the sudden collapse occurred. When I saw the patient, shortly after her admission to the German Hospital, she was moribund; extremities cold, radial pulse not to be felt, abdomen tympanitic. Vigorous stimulation was resorted to. In a few days the patient rallied and an examination was made. External palpation revealed an exudate on the left side of the abdomen. *Per vaginam*, three silver-wire sutures in the cervix were felt. Posterior to and mostly to the left side of the uterus, filling the entire pelvis, a large mass was made out which, however, did not seem to

communicate with the exudate felt externally. An incision along Poupart's ligament was made and about a pint of sero-purulent fluid evacuated. The cavity, which did not communicate with the peritoneal cavity nor with the mass felt below, was washed out and drained, with great improvement in the patient's general condition. About a week afterward the patient was anæsthetized and an incision made, *per vaginam*, into the pelvic mass. A quantity of fœtid blood and blood-clots, together with a macerated, three-months' fœtus and disorganized placental structures, were removed and the cavity thoroughly irrigated and packed with gauze. Unfortunately, in trying to remove all the placental structures the sac was ruptured, and a coil of intestine protruded. Still, I was able to push it back and apply the gauze dressing in a satisfactory way. For several days the patient had high fever and well-marked peritonitic symptoms. Within a week, however, the temperature became normal and the cavity commenced to grow smaller. About six weeks afterward she was discharged in good condition. I have seen her off and on since and have learned from the family physician that she has had repeated peritonitic attacks, several of them of a very severe nature. She now asked for admission in order to have the radical operation performed, as she is tired of being more or less an invalid all the time. Examination, under ether, showed a swelling on the left side of the uterus and the uterus fixed. On the 19th of December the abdomen was opened. Considering the history of the patient, comparatively few adhesions were found. The left tube was universally adherent and reduced nearly to its normal size, but it showed plainly where the original rupture had taken place over two years ago. The right appendages were also adherent and matted together; the uterus large and showed free oozing from where the adhesions were severed. Total extirpation of uterus and appendages, pelvis packed with iodoform gauze, so as to cover all raw surfaces and abdominal wound closed. Absolutely smooth recovery and the patient was discharged on the 26th of January, 1894. The specimen was exhibited before this society at a previous meeting. The patient has since reported to me, as free from all former complaints.

CASE III.—The patient, aged thirty-one, has had two children; the last one twenty months ago. Last menstruation on October 20, 1893. Cessation of menses until eight weeks later, when she had a severe metrorrhagia with violent pains in the left side. Since that time the hæmorrhage has never ceased, sometimes being very severe; pains constantly, with occasional exacerbations. She was referred to

me by her family physician, but as she could not at once be accommodated in a suitable room in the German Hospital she went to another city hospital, where she was curetted by one of the attending gynaecologists and discharged after one week. In addition to her hæmorrhages, she now had chills and high temperature. On the 15th of February she was admitted to the German Hospital. Examination under narcosis revealed a large uterus, on the right side of which was found a swelling of a doughy consistence and of about the size of a child's head; abdomen tender and slightly tympanitic. On the 20th of February the abdomen was opened and about a pint and a half of liquid blood was found in the abdominal cavity, with enough coagulated blood to fill a quart measure. The right tube was distended by blood-clots to about the size of a child's head and could not be separated from the posterior surface of the uterus. On the upper side near the fimbriated end the point of rupture was plainly seen. On the left side the tube contained pus, was occluded and matted together with the ovary, so that it had to be shelled out from universal adhesions. Some years ago I would have extirpated the two appendages and drained the cavity according to the Mikulicz method, taking the risk of a large ventral hernia. In the light of our modern experience with hysterectomy, I did not hesitate a moment to make up my mind to extirpate the uterus together with the diseased appendages. There was no way of saving any of them and, as the woman had to be castrated anyway, I deemed it infinitely better and more rational to remove the uterus which had become an absolutely useless organ. There was no palpable disease in the uterus; still, peeling off the right tube would have left a large raw surface on the posterior wall of the uterus, inviting intestinal adhesions and subsequent suffering.

The result was gratifying in every respect; the patient's temperature never touched 100° and she was discharged March 14th, three weeks after the operation. She is in perfectly good health now.

CASE IV.—The patient, thirty-eight years of age, a native of Poland, was admitted to the German Hospital on March 2d. It was difficult to obtain a satisfactory history, as the patient could only speak her native tongue. She had had two children, the last one eight years ago, and no miscarriages. She had been menstruating regularly until three months ago. Six weeks ago she had severe pain in the right side, which caused her to faint. The same day severe hæmorrhage set in, which has kept on, more or less, ever since. Colostrum in the breast; uterus large and softened. On the right side a mass, about the size of a grape fruit, of a doughy consistence.

The probable diagnosis of a right extra-uterine pregnancy was made. On the 6th of March a cœliotomy was performed and the diagnosis confirmed. There was a large amount of dark blood and blood-clots in the abdominal cavity, the right tube distended by blood-clots and chorionic structures and the place of rupture easily found on the upper border; the left tube thickened and occluded; the left ovary contained a hæmatoma. I admit that there might have been a possibility of resecting part of the left tube and of extirpating the hæmatoma of the left ovary and, in this way, of doing some so-called "conservative surgery." But, considering that this patient was a working-woman, who had to depend on her ability to work for a living, and taking into account that the resection of the tube, as advocated by Dr. Polk, is still in the experimental state, I felt that I was doing the right thing by this woman to perform a radical operation and, therefore, removed the uterus and all. There was another point to be considered and that was that the case clearly demanded drainage. Believing that drainage through an abdominal wound is one of the most frequent causes of ventral hernia, I preferred to drain through the vagina and close the abdominal wound. The patient's temperature was 101° in the rectum on the following day but fell to normal after the bowels had moved on the second day. The further recovery of the patient was without an untoward symptom and she was discharged cured, April 1st.

In both of the last-named cases, microscopic examination showed chorionic villi and thus proved the existence of extra-uterine pregnancy, although the fœtus, which evidently had perished before, was not found.

I suppose it is needless to state—still I might do so in order to avoid any possible misunderstanding—that I would never think of performing a hysterectomy in a case of ectopic gestation with perfectly healthy appendages on the other side. In fact, I have operated during the same period of time on several extra uterine pregnancies, where the radical procedure was not indicated. Among these was a case, where I had removed a tubal pregnancy from the right side over two years ago and was called upon to remove the left pregnant tube this winter. There being but few adhesions and the uterus, which was curetted, being healthy, it was left and has not troubled the patient.

The points I wish to emphasize are briefly these :

1. If you meet with a tubal pregnancy and find the other appendages in such a state that their removal is necessary, it is better surgery

to remove the uterus at the same time, thus saving your patient all subsequent trouble.

2. Even if there be a doubt whether a part of the ovary on the other side may be saved, in the presence of such extensive adhesions as will create a large, raw oozing surface on the posterior wall of the uterus necessitating free drainage, it is infinitely better to remove that uterus and secure drainage *per vaginam* than to leave it and drain through the abdomen.

In speaking of drainage, I mean drainage in the *surgical* sense of the word, implying a rather larger opening at the lower angle of the abdominal incision and a generous use of gauze ; not a little drainage-tube, through which hardly more than the exudation caused by that foreign body itself in the peritoneal cavity may be pumped up.

