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[Reprinted from THE AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, Vol. XL., No. 2, 1899.]

SOME NEW INSTRUMENTS TO FACILITATE THE OPERATION OF MYOMETOMY.

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(With two illustrations.)

It is difficult to give adequate expression to the satisfaction I have felt for some years past in discovering that I was able to treat a large percentage of myomatous uteri by the enucleation of the tumors, leaving behind the entire uterus and so avoiding any mutilation.

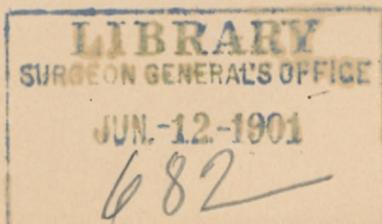
It has fallen to my lot in several instances to treat in this way young women who anticipated marriage; in a considerable number of other cases, young married women were childless and exceedingly anxious not to be deprived of the hope of offspring.

I have for this reason treated over a hundred cases by myomectomy and have long since adopted this operation as the operation of election within certain easily definable limits. I would therefore perform myomectomy, no matter what the number or site of the tumors, in all cases where the level of the myomatous uteri is below the umbilicus and in selected cases where the uterus rises well into the upper part of the abdominal cavity.

I would not do a myomectomy where the advanced stage of the patient made it useless, or where disease of the tubes and ovaries made the conservation of the uterus useless, or where the patient was so exhausted by hemorrhage or some complicating conditions as to make it imperative to complete the operation as quickly as possible.

Myomectomy is more dangerous than hysteromyomectomy

¹ "Conservative Treatment of Myomatous Uteri," Journal of American Medical Association, October 2, 1897. "Abdominal Myomectomy," Transactions of American Gynecological Society, vol. xxiii., 1898, p. 221; 90 cases.



and must therefore be performed with greater deliberation and with greater care in each step of the technique.

Myomectomy is more dangerous because in each case the operation must be individualized, while in hysteromyomectomy the operation has assumed more or less of a routine character.¹

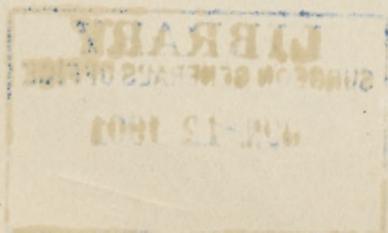
In myomectomy there is greater danger of hemorrhage because of the numerous vessels which it is necessary to control in the different planes of the uterine tissue, while in hysteromyomectomy the hemorrhage is controlled by the ligation of the four vascular trunks.

Myomectomy is also more dangerous than hysteromyomectomy because, while in the latter operation the tissues handled for the most part are those which are to be removed, in myomectomy there is a great deal of handling of tissues which are finally dropped back into the abdominal cavity.

In performing a myomectomy I would insist upon the following precautions: In the first place, the hemorrhage must be checked throughout by using the necessary number of interrupted, serpentine, or mattress sutures, applied with particular care to the areas which are most inclined to bleed, in two or even three layers, from the bottom of the wound to the peritoneal surface; in the second place, to avoid the risks of increased handling, both operator and assistants must wear rubber gloves throughout the entire operation.

In doing so many myomectomies as have fallen to my share within the past two years, I have striven to facilitate the steps of the operation by devising two forms of instruments for the purpose of removing the tumors from their beds. In a considerable number of cases I have used a spatula-shaped instrument devised by Dr. Cullen and figured in my "Operative Gynecology," vol. ii., page 359. I have recently devised a more satisfactory enucleator, which is provided with a stout handle affording a strong grasp to the fist, 12 centimetres long and $2\frac{1}{2}$ centimetres wide, with a slightly curved blade 12 centimetres long, in the smaller instrument $1\frac{1}{2}$ centimetres and in the larger $2\frac{1}{2}$ centimetres wide. The enucleating edge is serrated, the teeth in the larger instrument being eleven in number and at intervals of 0.5 centimetre, while in the smaller instrument there are fourteen teeth at intervals of 0.4 centimetre; in

¹ Fritsch: "Sind Laparomyomotomien typische Operationen?" Volkmann's Sammlung klinischer Vorträge, No. 241, 1899.



either case the teeth are not pointed, but present a curved margin, while their edges measure 1 and 0.5 millimetres in thickness respectively. The forms of the ends are shown in the text and the instrument is shown reduced in size (Fig 1). These instruments are used in the following manner: The uterus with the myomatous tumors is exposed and brought out, if possible, and surrounded with gauze. The uterine circulation is controlled either by a gauze rope or by the hands of an assistant grasping the cervix. The most accessible tumor is attacked first by making an incision boldly through the uterine wall and extending it sufficiently deep down into the tissue to expose the

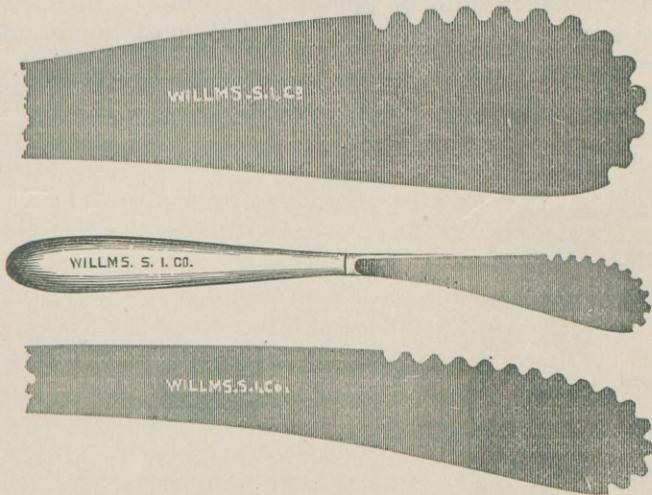


FIG. 1.—Myoma enucleator.

tumor perfectly, when it is grasped by a pair of Museaux forceps and pulled forward. Then with the enucleator, with its crenate margins and rounded teeth, the uterine tissues are rapidly stripped back and the tumor dissected out of its bed with a facility which is surprising. The crenations on the end of the enucleator are beautifully adapted to catching the muscular fibres and rupturing them at their point of entrance into the tumor with a minimal amount of injury to the tissues. The larger enucleator is used for larger tumors, the smaller for those of medium size.

For little fibrous nodules from the size of a pea up to that of

a cherry I have constructed a little myoma pick (see Fig. 2), which is plunged into the tumor and serves to lift it rapidly out of its bed while it is detached by knife, scissors, or small crenate enucleator.

The advantages obtained by the use of these instruments are

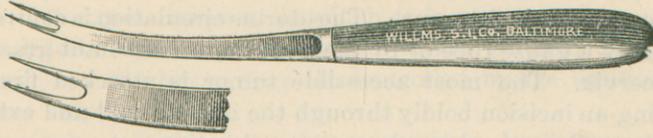


FIG. 2.—Myoma pick.

the material shortening of the time of operation, the lessening of the amount of trauma, and, what is most important, the entire absence of any actual handling of the parts; besides which the entire tumor is removed without leaving any slivers or bits behind, as is often done where the knife is used for purposes of enucleation.