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DEMONSTRATION OF SPECIMENS.

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Several weeks ago, at a meeting of this Society, Dr. Kelly spoke at length on the operative treatment of myomata and pointed out the ease with which these growths could be removed. Since that time I have operated upon two patients where the conditions present rendered the enucleation very difficult. Both of these cases present so many clinical points of interest that we may profitably discuss them for a few moments.

CASE I. *Umbilical hernia; multinodular myomatous uterus; large ovarian abscess communicating with the small intestine; hysterectomy.*

R. L., æt. 40. Admitted to Dr. Kelly's service March 23, 1897. Complaint, abdominal tumor, pains in the lower right abdomen and leg. She had been married 20 years, but gave no history of pregnancy. Menses began at 12 years, and were regular until August 15, 1896, when they ceased for 4 months, since which time they reappeared. Flow moderate, at times clotted; occasionally it is painful.

Family history negative.

Previous history unimportant.

*Present condition.* Ten years ago she noticed a tumor about the size of an egg in the right side of the pelvis. This has steadily increased in size and has been almost constantly associated with a gnawing pain over its most prominent part. The pain has been so severe that she has at times been confined to bed, on one occasion for 3 months. The last attack was 3 months ago. Locomotion very difficult on account of pain in the legs. These are at times swollen and pit on pressure. No chills. No fever. The

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\* Johns Hopkins Hospital Medical Society, May 17th, 1897.

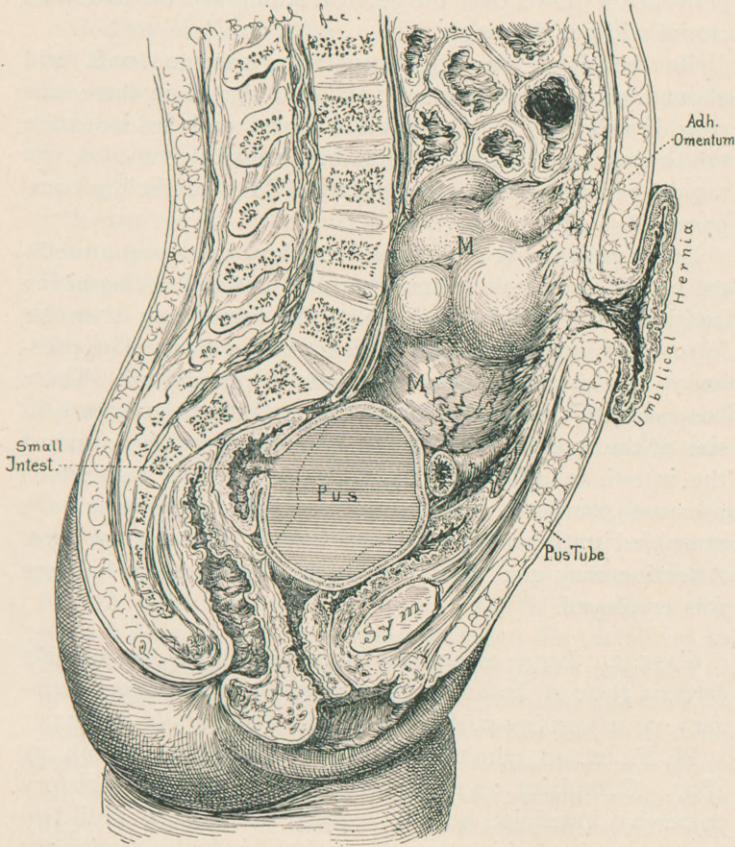
patient is well nourished, has a good appetite, bowels constipated. For the last two years she has had night sweats regularly.

The abdomen is much distended and presents an irregular lobulated appearance. At the umbilicus is a hernial sac fully 9 cm. in diameter. The skin over this can be drawn out for a distance of 6 cm., while the hernial ring whose margins are very sharply defined is 2 cm. in diameter. The following are the abdominal measurements: Distance from symphysis to umbilicus 14 cm.; from umbilicus to xyphoid 29 cm.; circumference at most prominent part of tumor 126 cm.; midway between umbilicus and xyphoid process 96 cm. Examination occasioned little pain.

*Operation March 24, 1897.* On account of the irregular hernial protrusion the abdominal incision was commenced at a point midway between the xyphoid cartilage and the umbilicus and continued downward to within a short distance of the pubes, the hernial sac being encircled and removed. At the umbilicus the omentum which was firmly adherent was ligated and then freed. Presenting at the incision were several subperitoneal myomata; to these the omentum was also firmly adherent. After loosening up these adhesions, the nodular myomatous uterus, 28x21 cm., was delivered. (See the accompanying figure.)

Occupying the posterior part of the pelvic cavity was an elastic tumor 17 cm. in diameter; this looked like an ovarian cyst and was intimately adherent to two loops of small intestine. On attempting to shell off the outer layers of the cyst leaving them attached to the intestines, the cyst ruptured and was found to contain about 900 cc. of greyish foetid pus. A glass trocar was introduced and the pus evacuated. The uterus was then removed in the usual way from left to right, but the left tube and ovary were left *in situ*. After bringing the cervical stump together the ovarian abscess was freed and the vessels at its pedicle controlled by silk ligatures. It was necessary, however, to leave a small part of the sac attached to the intestines, and on careful examination an opening 1 cm. in diameter was found between the intestine and the abscess sac. The margins of the intestinal opening

were almost as dense as cartilage and at the same time very friable. After a good deal of dissection it was possible to



A longitudinal section of the abdomen, showing from above downward the large multinodular myomatous uterus, to the upper and anterior surface of which the omentum is adherent, an umbilical hernia to whose ring the omentum has become adherent, a pus tube and an unusually large ovarian abscess which communicates with a loop of small intestine. The abscess was more on the right side of the body, but has been drawn on the same level to bring it out more clearly.

turn the edges in and the opening was closed by fine silk sutures. This now was supported by a second and a third row.

During the entire operation, which lasted 5 hours, the patient did not lose 3 oz. of blood. The abdomen was thoroughly cleansed with two litres of salt solution, the pelvic peritoneum drawn over the cervical stump and the abdomen closed without drainage.

On the eighth day the temperature rose to 100.8° and about the 20th day reached 101°. At that time there was considerable pain in the left iliac fossa and an indefinite thickening could be made out, but from this time on she rapidly recovered and was discharged May 4th feeling comparatively well.

From this case we may learn that where there is an umbilical hernia or adhesions are suspected it is well to begin the incision at a point above this; the finger can then be introduced into the abdomen to act as a guide. The presence of the ovarian abscess is very readily explained. There has evidently been an ovarian cyst. With the increase in size of the myoma the cyst has been firmly pressed against the intestines, adhesions have formed, and as continuous pressure promotes absorption, the walls have gradually atrophied until an opening has formed between the two. Attention may also be drawn to the fact that no drainage was employed.

*CASE 2. Large myomatous uterus extending out laterally between folds of broad ligament; complete hysterectomy necessary, as no cervix was left; danger of injuring the ureters.*

M. F., æt. 40, admitted to Dr. Kelly's service March 29, 1897. Complaint, an abdominal tumor. Menstrual history somewhat indefinite, but the periods were regular until two years ago, since which time the patient has had a continuous but not excessive bloody discharge.

*Family History.* Mother's family showed a decided tuberculous tendency.

*Present Condition.* She first noticed abdominal enlargement during the summer of 1896. It has steadily increased since then and showed more advancement on the left than right side. During the last four years she has had on an average one profuse uterine hemorrhage each year; the last

was one week before admission and continued three days. For one year there has been marked but not constant pain in the lower abdomen. Micturition frequent. No history of chills or fever.

*Abdominal Examination.* The abdomen is the size of a full term pregnancy, the greatest prominence is to the left of the umbilicus. Just below the umbilicus in the mid-line is a hard flattened area 8 cm. broad, to the right of which is a second nodule. From the character and consistence of the nodules one instantly suspects myomata.

*Measurements.* Distance from symphysis pubes to umbilicus 24 cm.; from umbilicus to xyphoid process 20 cm.; from right ant. sup. spine to umbilicus 25 cm.; from left ant. sup. spine to umbilicus 24.5 cm., girth at umbilicus 88 cm., greatest girth which is 8 cm. below the umbilicus is 91 cm.

On vaginal examination the cervix was felt as a half-moon-shaped slit directly behind the pubes, while the whole upper part of the pelvis was filled with a hard globular mass; forming a part of that occupying the abdomen.

*Operation* March 31, 1897. Hysteromyomectomy. The abdominal incision extended from a point 4 cm. above the umbilicus almost to the pubes. The myoma was delivered without difficulty, but found firmly fixed in the pelvis. Upward it reached a point midway between the umbilicus and xyphoid cartilage, was lobulated and laterally stretched out under the broad ligaments. The right round ligament was tied and cut, the vessels of the right tube and ovary were controlled and the appendages on this side were left *in situ*. On the left side the tube and ovary were found lying on the upper surface of the tumor and could not be saved. After ligating and cutting the left round ligament the folds of the broad ligament were separated, exposing an artery 2 mm. in diameter lying on the surface of the tumor—this was probably the ovarian artery; it was tied off and the bladder peritoneum freed from the tumor. The myoma was then rolled upward and to the right, but on the left side the uterine vessels as such could not be isolated; they were, however, controlled by passing stout sutures at their usual site.

It was now my intention to amputate at the cervix, but as this was entirely involved by the tumor the vault of the vagina was opened into, its upper portion being removed. The right uterine vessels were caught by the forceps and the tumor was freed. In both broad ligaments were many dilated lymph spaces. After controlling the large vessels with silk and checking all oozing along the vaginal cut surface with catgut the vaginal mucosa was turned down into the vagina and the raw surfaces were brought together, thus shutting off the pelvic cavity. The bladder peritoneum was then drawn backward over the stump and united with that of Douglas' sac. Considerable anxiety was felt as to the safety of the ureters, as it was necessary on account of the vaginal vault being so widely opened to control the uterine vessels further out than usual. On the left side a rounded cord was seen included in the ligature, but on unraveling this it was found to be a fold of peritoneum. After washing out the pelvis with two litres of salt solution the abdominal cavity was closed. The patient made a perfect recovery and was discharged May 3, 1897.

In this case the chief anxiety was centred around the ureters. We were loath to close the abdomen without further examination as to their safety, but the patient's condition did not warrant any delay. Strict orders were given to have all the urine measured to determine if sufficient were secreted. The amount obtained satisfied us that both kidneys were doing their normal amount of work. Had a ureter been tied the abdomen would have been again opened and the ureter anastomosed into the bladder.







