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Demonstration of Pathological Specimens.

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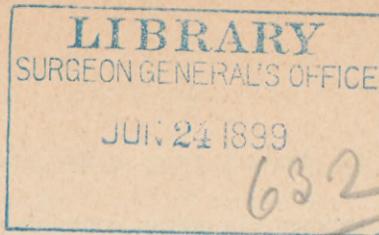
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SURGEON IN CHIEF OF THE AGUSTANA HOSPITAL, ETC., CHICAGO.

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DEMONSTRATION OF PATHOLOGICAL SPECIMENS.

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My first specimen, a uterine fibroid, was removed from a patient forty years of age. She had previously been healthy, and there was no history of pathological growths of any kind in the family. She had first menstruated at sixteen; had borne one child at twenty-eight. At the age of thirty-five menstruation began to be profuse. Internal remedies were without benefit. Eighteen months before she came under my care she first noticed a tumor in the region of the uterus, but paid no attention to this. In the meantime the hemorrhages became so severe that the patient was extremely anemic and almost unable to be about. Two days before the patient came under my care she began to suffer suddenly from severe labor pains. Her physician, Dr. Edward Cross, examined her and found the uterus contracting upon this tumor; he administered an anodyne, but the pains continued for two hours until the cervix was fully dilated. Upon examining the patient I found this tumor presenting through the fully dilated cervix like the head of a child. I introduced first one finger and later the entire hand between the tumor and the uterine tissues and carefully separated all the adhesions up to a point shown on the specimen by these rough fibers which were separated later. I now applied obstetrical forceps to the growth, and finding it impossible to deliver without rupturing the perineum I made a lateral incision through this structure. It required much force to deliver the tumor through the pelvis. The cavity of the uterus was at once carefully packed with iodoform gauze and the wound in the perineum closed with deep silk sutures. The tumor is oval in form and measured at the time of its delivery fifteen inches in its smaller, and twenty-two inches in its greater, circumference. It is a simple fibro-myoma and remarkable only, aside from the unusual method of its removal, for the fact that it grew to such a size in its submucous position without giving rise to uterine contractions. On the fourth day after the operation I removed a portion of the iodoform gauze packing, and the remainder on the ninth day. After this time the

patient received hot douches twice daily until the wound had healed.

The second specimen is a uterus, containing myomata, which I removed by vaginal hysterectomy five weeks ago from a patient thirty-six years of age. She was married at the age of eighteen, and has been a widow since her twenty-third year. She was never pregnant. She began to menstruate at the age of thirteen, always suffered severely, and during the past three years the flow has been very profuse. Eight months ago a surgeon in Minneapolis performed an abdominal section for the removal of a uterine fibroid, which could be felt through the abdominal wall. He found inflammatory adhesions and removed both ovaries in the hope of thus stopping the hemorrhage. For six weeks after the operation the patient seemed relieved, but there was a sudden recurrence of the hemorrhages, which were so severe that the patient became almost bloodless. It was necessary to keep the uterus and the vagina tamponed constantly in order to control the hemorrhage, which would recur immediately upon removing the tampon. During the three years of her illness the patient had received careful medical treatment almost constantly, but this had been of little or no benefit.

Under these conditions I decided to remove the uterus by vaginal hysterectomy, after dilating the cervix sufficiently to insert my finger and finding nothing which seemed sufficient to cause such profuse bleeding.

The operation was performed in the usual way, by making an incision through the mucous membrane around the cervix, opening the peritoneum anteriorly and posteriorly by blunt dissection, grasping the tissues on each side with strong forceps and cutting them on the side of the uterus. The operation was unusually difficult because of the numerous adhesions and the thickening of the surrounding tissues due to inflammatory conditions which had previously existed. All the blood vessels were very much enlarged and required the application of forceps and ligatures at points which under ordinary conditions do not require any attention. After ligating most of the portions of tissue held by the various forceps I tamponed the wound with iodoform gauze and left several of the forceps in place. The forceps were removed after two days; portions of the gauze packing three days, and six days later; and the remainder twelve days after the operation. From this time on the patient received hot water douches night and morning until the wound had closed.

The specimen shows an intramural fibroid tumor as large as a walnut in the upper portion of the uterus, and a submucous fibroid as large as a filbert in the upper part of the posterior wall; and it was this smaller tumor which gave rise to the enormous hemorrhages which the attending physician described as having been almost as alarming as post-partum hemorrhages, controllable only by very careful tamponing. This can be accounted for by the presence of these enormously enlarged blood vessels, which can be appreciated even now after the specimen has been preserved in alcohol for over a month.

This third specimen, consisting of a uterus and three fibroid tumors, each one as large as an orange, and several smaller ones, I removed by vaginal hysterectomy ten days ago from a patient sixty years of age. She menstruated at sixteen; was married at twenty, gave birth to a healthy child at twenty-one and had five miscarriages after this, the first one being caused by a fall. At the age of thirty-four she noticed an abdominal tumor which was diagnosed as a fibroid of the uterus. It increased in size, notwithstanding medical treatment, until it reached the size of a six months' pregnancy. At this time the patient fell into the hands of a charlatan who gave her rubbings of personal magnetism, and as about this same time the tumor began to decrease in size it was attributed to the magnetism.

You notice that one of these three tumors is very hard and white and cuts like dry putty. It is composed very largely of calcareous deposits which have accumulated during a period of degeneration extending probably over more than twenty years, judging from the history. It is probable that at that time the growth was twenty times, its present size.

The other fibroids are of recent origin and do not contain any calcareous deposits.

The patient suffered from her thirtieth to her fifty-second year from profuse and painful menstruation, and for the past five years from pain caused by the pressure of this hardened fibroid upon the bladder and the rectum. During the past few months this pain has become almost unbearable, possibly from the weight of the two new tumors upon the original one.

The operation consisted in making the ordinary incision around the cervix and making a blunt dissection anteriorly and posteriorly. Feeling this calcareous tumor in the cul-de-sac, I loosened the adhesions with my finger and enucleated the tumor. Then the broad ligaments were ligated and the uterus, together

with the remaining tumors, were removed with some difficulty. The wound was tamponed with iodoform gauze, which was partly removed on the fifth day, and the remainder on the tenth, leaving the healing to be completed in the usual way.

The next specimen is a carcinoma of the rectum which I removed two weeks ago by Kraskes' method from a patient forty-nine years of age. The patient had been healthy until one year ago, when he began to suffer from bearing down pain and an inability to have a free evacuation of the bowels. An examination showed this circular carcinoma to be located about five inches above the anus at the junction of the sigmoid flexure and the rectum.

In order to prevent dangerous infection from the passage of feces over the wound I performed inguinal colostomy according to Mydls' method a week before resecting the rectum.

The operation consisted in the following steps: An incision was made from the left sacro-iliac synchondrosis to a point just above the anus. After reflecting the soft tissues down to the sacrum and coccyx, the sacrum was chiseled off transversely through the upper part of the fourth sacral vertebra. The lower portion, together with the coccyx, was removed. This exposed the tumor perfectly. It was now easy to loosen it by blunt dissection. Its anterior surface was covered with peritoneum, which had to be removed in order to prevent recurrence in this location, so I opened the abdominal cavity on each side of the intestine and introduced a sponge, to which a strong silk cord had been attached, in order to prevent the protrusion of intestines during the remainder of the operation. A clamp was now applied to the intestine one and one-half inches above the tumor, another one-half an inch lower, and another one an inch below the tumor. The lower end of the bowel was now cleansed in order to prevent infection from this source. The tumor was then removed by severing the intestine above and below the two clamps on each side of the tumor. In this instance the sigmoid flexure of the colon was very long, so it was possible to bring down the severed intestine from above, draw it through the anus, and hold it in place by means of half a dozen silk sutures which were tied over rubber adhesive strips. The peritoneal cavity was shut off with catgut stitches and the wound packed with iodoform gauze.

This method enables one to perform the operation in from twenty to forty minutes without fear of hemorrhage or infection, because the entire field is exposed to view, which, moreover, aids greatly in making a thorough removal possible.

The next specimen consists of an enterolith almost cubical in form, as large as a hickory nut, which has the appearance of a gallstone. I have examined it microscopically and find it to consist of fecal matter intermixed with enormous numbers of bacteria.

Twelve years ago the patient, a lady 25 years of age, suffered from peritonitis confined to the region of the cecum. This attack occurred two days after the patient had fallen from a horse and it was thought that the fall had caused the peritonitis, but later it was supposed that there was no relation between the fall and the peritonitis and that the patient had an attack of appendicitis. She was confined to bed for six months and has had pain in the region of the cecum ever since that time. Whenever she attempted to ride in a carriage or to exert herself there was a return of the peritonitis more or less severe.

Five weeks ago she had a recurrence so severe that she requested an operation, which I performed a little over two weeks ago, after the acute symptoms had subsided.

The operation consisted in the ordinary vertical incision half way between the umbilicus and the anterior superior spine of the ilium, exposing a condition which would be expected to exist after a severe attack of peritonitis. There were strong adhesions between the cecum, the ileum, the Fallopian tube and ovary and the bladder; and this enterolith could be felt plainly through the wall of the cecum. All the adhesions were carefully separated and the remnant of the vermiform appendix, about as large as the end of a thumb, was found to contain this enterolith. By manipulations it was dislodged and forced into the ascending colon, whence it was expelled on the following day with an evacuation of the bowel. The wound was closed with the exception of the ends, through which strands of gauze were passed down to the cecum. These were removed on the seventh day after the operation. It is of course impossible to tell how long this enterolith had existed, and whether it was the focus from which the infection came in each of these successive attacks of peritonitis.

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