Uterine fibroids complicated by pregnancy / by A. Vanderveer.

12.

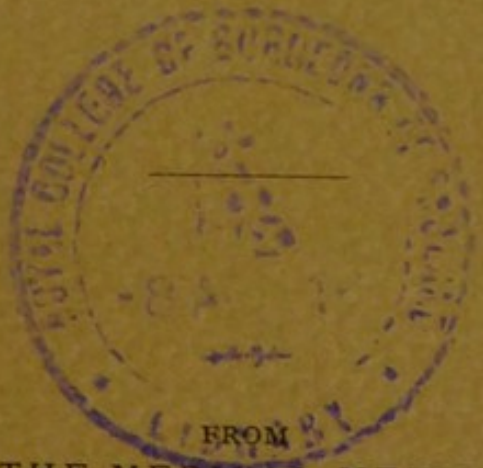
UTERINE FIBROIDS COMPLICATED BY PREGNANCY.

BY

A. VANDERVEER, M.D.,

OF ALBANY, N. Y.;

PROFESSOR OF DIDACTIC, ABDOMINAL, AND CLINICAL SURGERY IN THE ALBANY MEDICAL COLLEGE.



FROM

THE MEDICAL NEWS,

December 12, 1896.

[Reprinted from THE MEDICAL NEWS, Dec. 12. 1896.]

UTERINE FIBROIDS COMPLICATED BY PREGNANCY.[1]

BY A. VANDERVEER, M.D.,

OF ALBANY, N. Y.;
PROFESSOR OF DIDACTIC, ABDOMINAL, AND CLINICAL SURGERY IN THE ALBANY MEDICAL COLLEGE.

FOR many years careful obstetricians, consulting gynecologists, and general surgeons have witnessed the disappearance, in many instances, of uterine fibroids during the course of pregnancy; absorption has taken place beyond a doubt. Again, many have been the cases in which suppuration has occurred, and patients have died as a result of septic conditions, the source of which at the present time could have been reached and treated with success. There are, perhaps, few conditions that give the family physician so much anxiety as those of fibroid, in which the patient becomes pregnant. On the other hand, there is perhaps no class of cases that gives the abdominal surgeon so much cause for thought as the cases of fibroid in which there has been a marked reluctance on the part of the patient to submit to an operation, and yet in which there is sudden enlargement with suspicion of pregnancy, such as existed in the two cases I have to report. In these cases it was apparent to the patients and their friends that delay was not admissible, the chances for the patients' recovery resting entirely upon an early operation.

To-day we approach such conditions with a sense

[1] Read at the Second Pan-American Medical Congress, held in the city of Mexico, November 16, 17, 18, and 19, 1896.

of assurance that they are amenable to surgical interference, and that the recovery of the mother is certain in a large percentage of cases. And yet text-books do not refer to these cases with quite that emphasis that the conditions seem to demand.

Davis, in his recently published work[1] says:

"Pregnancy may occur in a fibroid uterus, and in such a case a most careful examination is required to detect the fact. It will usually be necessary to examine the patient under an anesthetic, and to map out carefully, if possible, the condition complicating the pregnancy."

Courty[2] makes the following convincing statement:

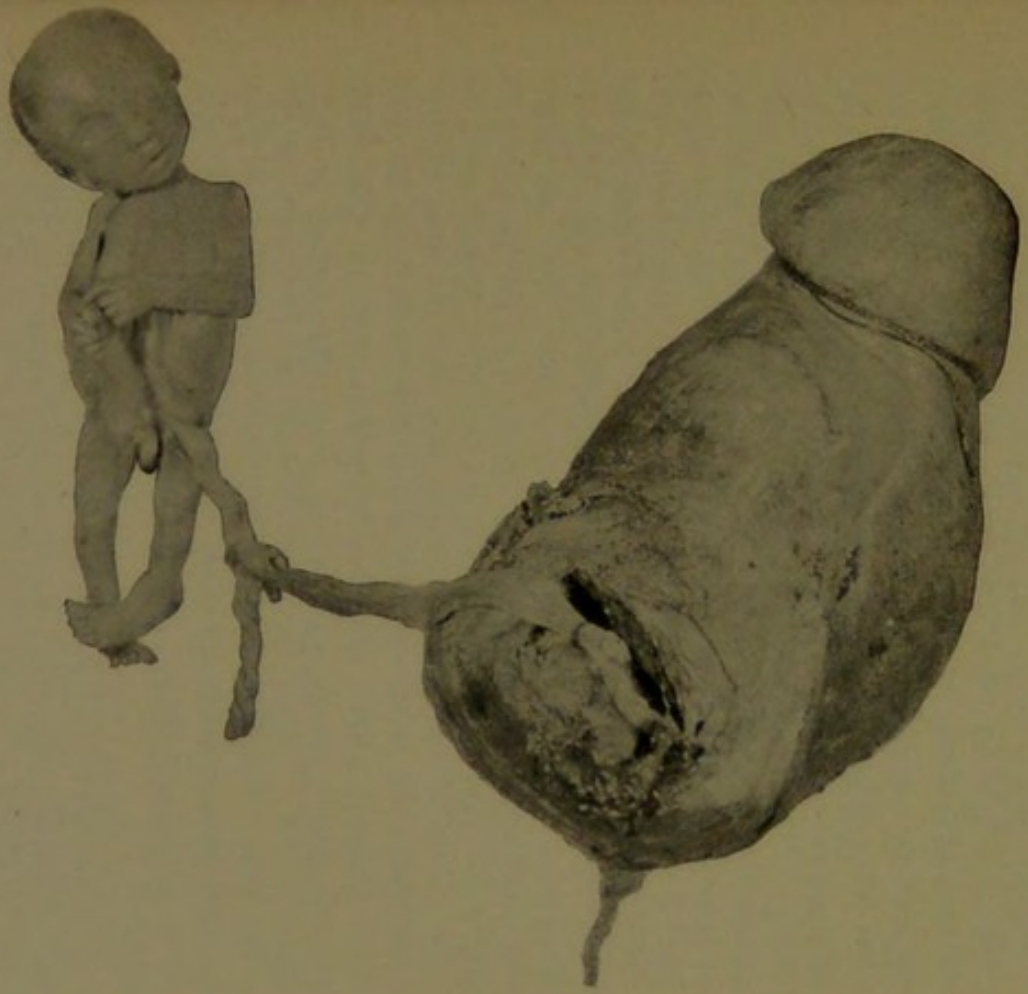
"There is no doubt that the presence of myomata diminishes the number of conceptions and increases that of abortions and miscarriages. Whether the presence of the fibrous tumor prevents the free development of the uterus, or whether it determines hemorrhage, it often causes abortion. Delivery may be impossible; it is always difficult, dangerous, and complicated, and it exposes to troublesome consequences. According to Tarnier, out of 42 cases delivery only terminated spontaneously 8 times; it required the use of forceps 6 times, version 6 times, induction of premature labor once, embryotomy once, enucleation of the tumor once, and Cæsarean section 14 times; the malady caused death 5 times before delivery (of these 42 patients only 13 were cured)."

I also quote from Mann[3] as follows:

"Pregnancy and labor are occasionally complicated by the existence of fibromyomata. The preservation of the life of the mother may depend upon the removal of the growth, the induction of premature labor, or Cæsarean section. Dr. Jas. R. Chadwick has published in a paper read before the Massachusetts Medical Society, at its annual meeting in June, 1895, a report and summary of 10 cases of pregnancy and labor complicated by existing fibromyomata. Of these cases, 1 miscarried, 2 died, and 7

[1] "Treatise on Obstetrics," p. 28.
[2] "Diseases of the Uterus," p. 634.
[3] "American System of Gynecology," vol. ii, p. 590.

FIG. 1.



Case 1. Lower segment of uterus containing fetus, opened.

recovered; in all of the 7 cases of recovery, the tumors were subperitoneal. The question of surgical operation for removal of these tumors during pregnancy is not a very difficult one to solve. When the tumor is subperitoneal and pedunculated, pregnancy is not a barrier."

It is to be observed that the subperitoneal and pedunculated varieties give comparatively little trouble in cases of pregnancy, and this may be said of the pedicled or sessile subserous fibroma, as the following extract from Pozzi[1] confirms:

"Pregnancy gives a lively impetus to the development of fibrous tumors, and often causes their edematous softening. The treatment depends upon the nature of the symptoms, and the seat of the tumor. If it is a pedicled or sessile subserous fibroma of the fundus, we may hope that it will not interfere with the course of pregnancy. If there is danger of inflammation or the transformation of the tumor into a fibrocyst, there is also a hope that it will disappear during the uterine involution, and we may therefore pursue the expectant treatment. In the case of pelvic fibroids, however, delay seems more dangerous; if they cause no very serious symptoms we may wait in the hope that they may either precede the fetal head at the time of parturition, as has been observed, or else will ascend above the superior strait after the rupture of the membranes. Often the labor is accomplished only after a duration which results in a fatal exhaustion, if the woman does not die at once of the hemorrhage. These risks decidedly limit the advisability of the expectant method."

These few extracts illustrate the dangers that present themselves to the obstetrician in cases of fibroids that interfere with the cavity of the uterus, or obstruct the outlet of the uterus or pelvis. I am indebted to Dr. Rosenwasser of Cleveland for some statistics presented in a recent paper.[2] He says:

---

[1] "Medical and Surgical Gynecology," vol. i, p. 327.

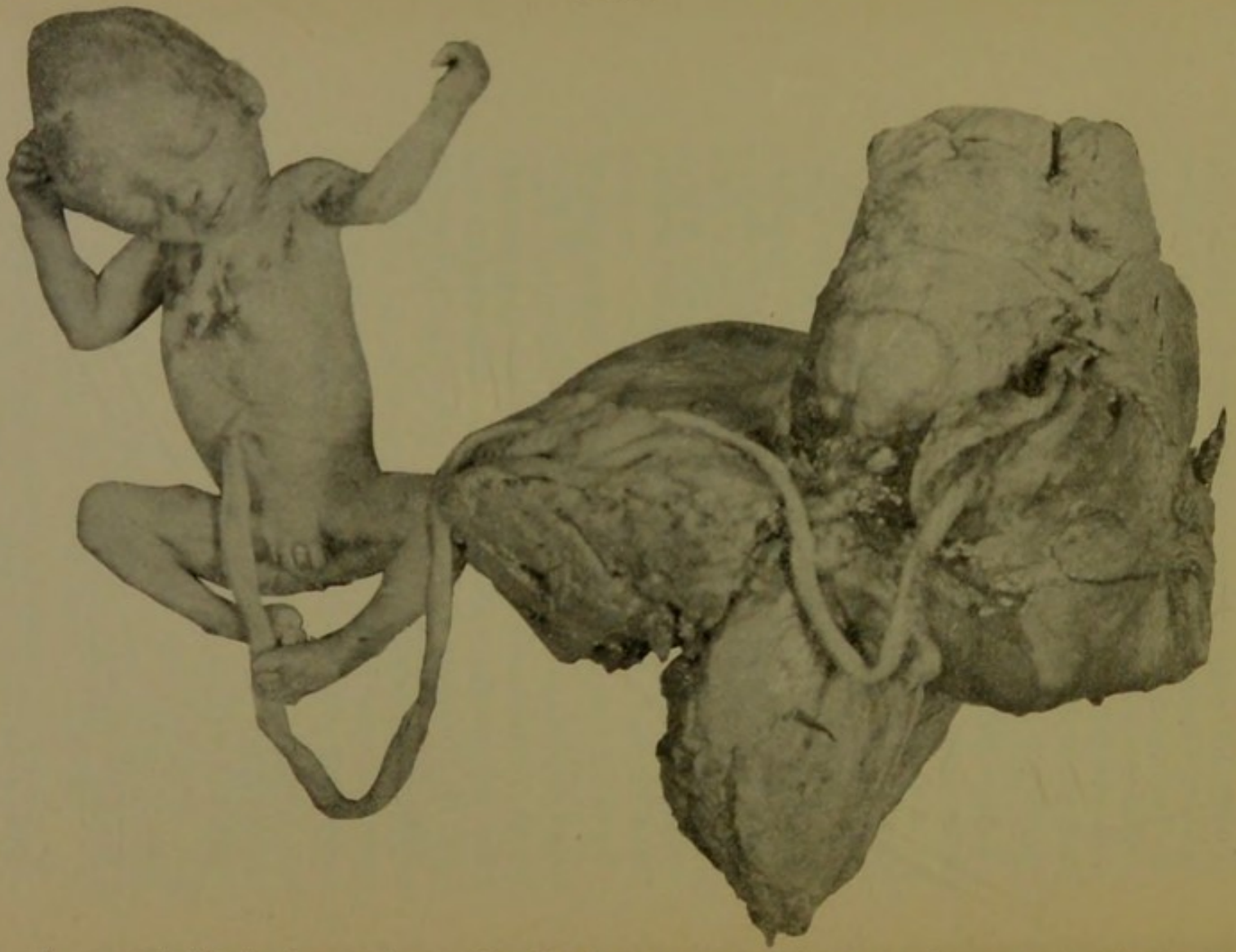
[2] "Report of Three Cases of Uterine Fibroids Complicated by Pregnancy," by M. Rosenwasser, M.D.

"Of 228 cases of labor complicated by fibroids, collected by Güsserow,[1] more than one-half of the mothers and two-thirds of the children died. The assumption that many of these deaths may have been due to meddlesome interference on the part of the obstetrician is contradicted by Güsserow's[2] carefully compiled tables. Among 147 cases of labor, collected by him, 78 mothers died. Of the 61 mothers requiring manual or instrumental aid, 33 died. The remaining 45 deaths were therefore among the 86 cases not interfered with. The labors allowed to go to a natural termination were undoubtedly those in which there was the least hindrance to delivery, and yet they ended as fatally as did those subjected to delay, injury, and sepsis. In the more recent statistics, collected by Stately,[3] there are 597 cases in which no interference occurred before labor. Of these 220, or 37 per cent., died. This reduction in the mortality is owing to the improvement in technic within the last ten years. Among 307 cases reported as having aborted, the death-rate was 12 per cent."

It would seem, then, that surgical interference, either by myomectomy or by hysterectomy, is followed by more favorable results than is gathered from the statistics above quoted. The number of cases thus treated is, however, as yet insufficient to enable us to formulate any fixed rules for general guidance. Each case must be considered on its own merits, and must be managed in accordance with the best interests of the mother, and, where possible, also of the child. Whenever the location of the tumor is not likely to interfere with delivery, or its moderate rate of growth will admit of delay until after the viability of the child, a conservative course is clearly indicated. Myomectomy in the interests of the

[1] "Cyclopedia of Obstetrics and Gynecology," vol. ix, p. 316.
[2] *Ibid.*, p. 314.
[3] *Johns Hopkins Hospital Bulletin*, March, 1894, p. 33.

FIG. 2.



Case 2. Tumor and child showing attachment of cord to lower segment of the uterus—the tumor extending into right lumbar region laid open.

child is justifiable in cases in which dystocia would become a strong probability. At or near term in event of obstruction to delivery, suprapubic hysterectomy is probably the safest course. The loss of mothers ought not to exceed ten per cent.; the children ought nearly all to be saved.

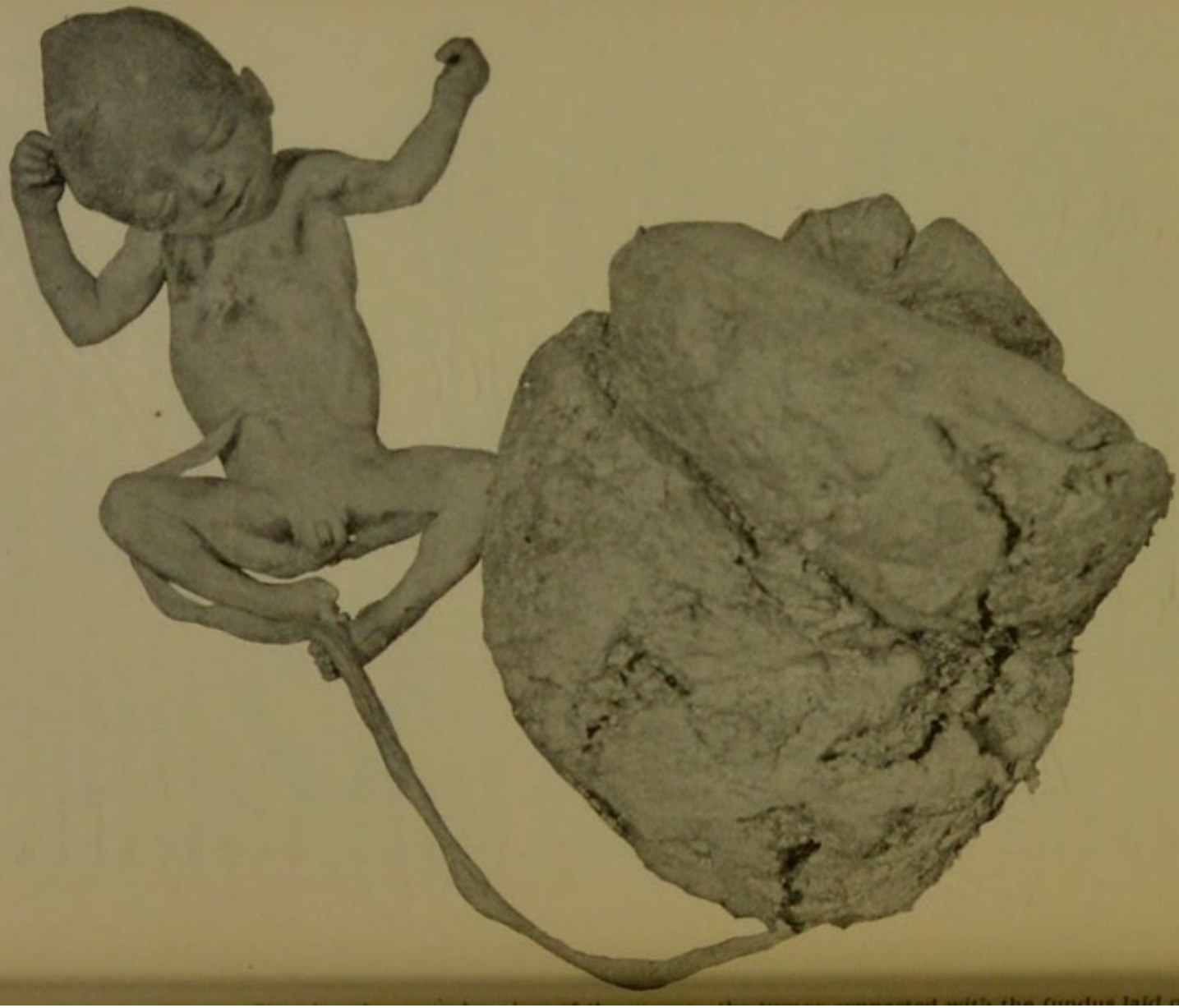
Dührssen's proposition[1] to deliver the child by vaginal Cæsarean section, and then to preserve the uterus, or remove it as the nature of the case might indicate, has yet to be put to the test of experience.

The two following cases are good illustrations of uterine fibroids complicated by pregnancy as met with at times in our surgical practice, and bring out strongly the points to which I wish to refer; they emphasize the necessity of thorough operation in a certain class of patients. Delay, in the hope of absorption, or in the hope of delivering a living child, can scarcely be tolerated.

Case I.—Mrs. X. came under my observation in August, 1893, with a history of continuous and severe uterine hemorrhage during the two preceding months. Treatment was readily agreed to, and in October, 1893, I removed an intra-uterine polypus without trouble, and carefully curetted the cervix and cavity of the uterus. After this she became absolutely regular in her menstruation, and improved decidedly. At the time of operation I discovered that she had an interstitial fibroid connected with the anterior wall of the uterus. She had borne several children, and had had no miscarriages. She was then forty-five years of age. The case progressed so favorably that no further examination was made until January 24, 1895, when I was greatly surprised

[1] "Der vaginale Kaiserschnitt," Dührssen, Berlin, pp. 27–33.

FIG. 3.



at the size of the abdomen, and found a hard mass in front, plainly the fibroid connected with the anterior wall of the uterus, which had increased very markedly in size. On the right side, and extending up into the right lumbar region, was an additional mass much larger than a child's head, which gave the feeling of fluctuation, and led to the supposition of its being an ovarian cyst. There was also to be felt deep down in the pelvis, by pressing the abdominal tumor well over to the right, a small mass that I believed to be the left ovary, and which fluctuated. She had had some trouble in getting her bowels to move, yet the constipation was relieved by proper laxatives. Her menstruation had ceased in September, 1894. She positively declared that she could not be pregnant, yet her husband felt there was a possibility of such being the case.

The patient's condition was such that it was not safe to wait longer before resorting to operative interference. The patient was becoming somewhat emaciated, pressure upon the stomach was interfering with digestion, and she was growing nervous and worried as to her condition. An eminent gynecologist saw her in consultation with me, and after two careful examinations announced that we had to deal with a uterine fibroid, with probably a double ovarian cyst, and that she could not be pregnant. There was an entire absence of any condition of the breasts indicating pregnancy, and at no time had she been nauseated. It is true that there was a slight port-wine discoloration to be noticed about the mucous membrane of the vagina, but the neck of the uterus could be distinctly made out, it was not dilated or softened in the least, and there was no discharge that gave us any strong impression of pregnancy.

Operation was decided upon and performed March 18, 1895. I found on opening the abdomen a large uterine fibroid. The mass that extended up into

the lumbar region was but a prolongation, and had commenced to soften, cystic degeneration taking place. The immediate steps in the operation were those of supravaginal hysterectomy, for what I believed to be a large fibrocystic growth. Each ovary was about the size of a turkey's egg, and cystic in character. The lower segment of the uterus could be distinctly mapped out from the fibroid and its associate cystic degeneration, and on lifting the entire mass from the abdominal cavity, using the rubber tube for constriction, I did a complete supravaginal hysterectomy, making use of the Koeberle serre-neud. As I removed the mass I realized that in making the section through the cervix, the incision had passed just below the membranes and amniotic fluid of a pregnant uterus. After proper care of the pedicle and closing of the abdominal incision, I found on examining the specimen a fetus of nearly four months' growth in connection with the fibroid tumor. There was nothing particularly eventful in the case afterward. The patient made an uninterrupted recovery, and has remained in the best of health since.

Case II was quite impressive. Mrs. E. S., aged thirty-five, had been married a little more than a year, but had had no miscarriages during that time. I saw her April 1, 1896, in consultation with her family physician, Dr. Wm. H. Bailey. She had been in a state of perfect health for a period of twenty-two years; menstruation had been regular, never painful, and had begun at the age of thirteen. She believed herself to be pregnant, although for the past year she had menstruated at irregular intervals. She had made all her preparations for confinement, supposing herself to be near the time of delivery. Her physician had said frankly to her that if she were pregnant he believed she also had an abdominal tumor, yet she did not wish an examination, and de-

clined it, being so firmly impressed with the belief that she was pregnant. When I saw her the abdomen was so tense that it was almost impossible to make out a correct condition of affairs. The left side of the abdomen presented a somewhat irregular, lobulated appearance, and felt exceedingly hard in certain places. The right side gave a more distinct appearance of an ovarian cyst. The patient had a pulse of 110, temperature ranging from 100° to 102° F., and she was vomiting quite constantly; there was some trouble in getting her bowels to move, and she was decidedly sick. I expressed my opinion that while there was a possibility of her being pregnant, I believed it was a case more particularly of uterine fibroid, possibly associated with ovarian cyst. Her breasts presented a negative condition as to pregnancy, and so did the neck of the uterus and the vagina.

An operation was decided upon and performed April 4, 1896. A large fibroid, multiple in character, was found, the details of the operation being almost precisely as in the previous case, a well-developed fetus of four months being present. The patient made a good recovery, the only marked symptom presenting in the after-condition being a decided delirium, that came on during the fourth day and continued nearly a week, which I attributed to her very anemic condition. Since the operation she has gained over twenty pounds in flesh, and presents a picture of health.

These two cases but a few years ago would have been beyond the reach of surgery. Such patients ought now to receive the prompt attention of the abdominal surgeon. It is possible that in some cases the living child, at full term, may be saved. There should be no hesitancy in removing the entire uterine

appendages, although the tumor may be much smaller than in either one of the cases here reported. If left to themselves, and the attempt made to do a Cæsarean section, suppuration may follow and septic conditions result in the loss of the patient. I am most emphatic in my belief that in cases of uterine fibroid, with suspected pregnancy, a careful, thorough examination should be made, and if there is a doubt as to the possibility of delivering the patient at full term, an early radical operation should be done.

It will be noticed in these two cases that the fetus occupied the lower segment of the uterus, and yet neither patient gave symptoms of an approaching abortion, although Case 2 was rapidly reaching a fatal termination. It is true that neither one of these cases illustrates very positively the course we should pursue at a time when viability of the fetus presents. We may possibly, as we do sometimes in cases of retention of urine, change the position of the fibroid, particularly if it is not large, or if it is not growing rapidly, so as to relieve the pressure, and development may go on to full term, when the child can be delivered, the tumor being of such a character that contraction takes place, and the mother and child live; but we all know of, and have had experience with, the dangerous hemorrhage that results at such a time, in some of these cases; we know of the lamentable record of prolapsus of the cord, constriction of the thoracic viscera, rupture of the uterus, and local, and sometimes general, peritonitis, with all the complications of adhesions to the intestines and omentum, so that even though the child may be viable we must consider the advisability of recom-

mending an operation at this time. Certainly, before viability is reached, we need not hesitate as to the course to be pursued, particularly when the evidence of constant enlargement of the tumor is present.

In the discussion of this subject it is my desire to emphasize somewhat the exclusion of the question of small tumors. It is only to the large ones, such as grow rapidly under the impetus of pregnancy, that I wish to call your attention. These cases left to themselves present a very high rate of mortality. They do not admit of myomectomy. A uterus with such large fibroids, and with cystic degeneration going on, will not admit of the patient going to full term; the condition demands prompt radical surgical interference.