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Reprinted from The Journal of the American Medical Association, October 20, 1906, Vol. xlvii, pp. 1299, 1300.

CHICAGO:
PRESS OF THE AMERICAN MEDICAL ASSOCIATION,
ONE HUNDRED AND THREE DEARBORN AVENUE,
1906.

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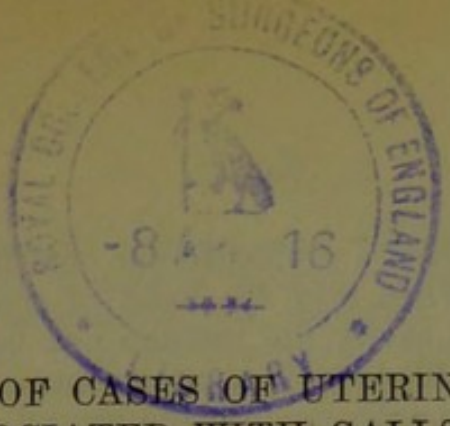

REPORT OF CASES OF UTERINE FIBROIDS ASSOCIATED WITH GALLSTONES.

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With the desire of impressing on the profession at large the importance of studying carefully all complications that may be present in a case of uterine fibroid, I report the following cases in four of which the history of biliary colic was pronounced, but in the others not so distinct.

For a number of years I have gradually become convinced, and am now fixed in my belief, which experience has confirmed, that, when opening the abdominal cavity for any operation, unless the patient is so weak that it is unsafe to make further examination, or to operate, the appendix should be thoroughly explored, and though there may have been no history of appendiceal trouble, still, if this structure is anatomically incorrect, or, if normal in position, has given the history of any previous attacks, I make it a rule to remove it.

As time passes, I am yet more strongly impressed with the belief that this rule is a good one, saving the patient possible further operative intervention.

For about eight years I have convinced myself that it is also good surgery to examine the gall bladder, and, if gallstones be present, to remove them. I feel disposed to insist on this, except, when, as before stated, the patients condition is so feeble that the risk is too great.

I am not aware that there is any pathologic relation between the gall bladder and pelvic troubles, or associated with uterine myomata, but the cases I have seen have been so pronounced that it has seemed proper to place them on record. When we consider these cases they certainly present some strikingly illustrative points regarding the thoroughness with which we should do our abdominal work. The performance of the operation of

cholecystotomy is not a prolonged one, and is very easily accomplished. When once the hand of the operator is in the peritoneal cavity the incision can be made very quickly, the gall bladder, if not too contracted, and far back, is easily brought up into the wound and reached in this manner.

It took many years to convince the general practitioner that the surgeon could be of assistance in his abdominal cases and reports of cases of rare complications are yet in order to bring before him more clearly what and how much can be done by the general surgeon in the treatment of lesions, no longer medical, but assuredly surgical. How many operations can be done on one patient at one time is yet a subject for close study by both the medical man and the consulting surgeon.

Case 1.—Mrs. C., aged 60, entered Albany Hospital, May 2, 1902.

Diagnosis.—Papillomatous ovarian cyst; cholelithiasis.

History.—She gave a family history of a sister and niece having died of sarcoma of the ovaries and mesentery. The patient had been ill for more than a year with gradual enlargement of the abdomen and more or less pain.

Operation.—On opening the abdomen there was an escape of a large amount of yellowish serous fluid. There were cysts connected with each ovary. The right broad ligament was clamped; the left broad ligament was sutured at once; then the appendages with the cystic tumors were removed and a supravaginal hysterectomy was done. An enlarged gland in the mesentery closely attached to the rectum was removed and the walls of the rectum were sutured over. There were extensive adhesions to the wall of the bladder and to the anterior wall of the uterus. In removing the latter a large portion of the posterior wall of the bladder was included. This opening in the bladder was closed with silk sutures. Hemorrhage was controlled. The gall bladder was found to contain many gallstones—over 100, and the usual cholecystotomy was done. The appendix was also removed. The wounds were closed with silkworm gut; a glass drainage tube was introduced into the bottom of pelvis and also into the gall bladder.

The patient bore the anesthetic very well. Drainage from peritoneal cavity subsided quickly and the gall bladder closed in about two weeks. She left the hospital in good condition June 8, 1902.

Pathologic Report from the Laboratory.—Multilocular ovarian cyst with secondary papillomatous and carcinomatous degeneration.

Subsequent History.—The patient did well for a time, then

the old symptoms returned with increased severity, and on May 25, 1903, I made an incision through the old scar and removed a sarcomatous cyst, somewhat flattened and larger than the fist, from the mesentery. Similar growths in the pelvis were not disturbed. A large amount of ascitic fluid was removed. She was tapped by her family physician at her own home, Sept. 13, 1903, and again October 17, when the doctor wrote me that he had withdrawn over ten quarts of fluid at one time, ill-looking and tinged with blood. After this last tapping careful examination revealed two large growths in right side of abdomen, about the size of the ones I removed at first operation. After these tappings the patient felt weak for a day or two, then comfortable, with a good appetite, but each time the cyst began to fill again rapidly, and she ultimately died of exhaustion.

CASE 2.—Mrs. H. G., aged 35, entered Albany Hospital Dec. 1, 1902.

Diagnosis.—Cholelithiasis; uterine myoma.

Family History.—Her father and mother both died of valvular disease of the heart, aged 64 and 58 years respectively. A brother died of typhoid fever, aged 31; a sister died at confinement of acute Bright's disease; three sisters are living and well. There was no history of so-called hereditary disease.

Personal History.—This patient has had attacks of biliary colic since childhood, never severe until four years ago, when character changed entirely, growing more severe, and she passed stones. Slight shooting pains were experienced occasionally through the abdomen, low down toward the umbilicus, and when on her feet she experienced a very weak feeling until thoroughly rested.

Operation.—Dec. 3, 1902. On opening abdomen multiple fibroids were found low down in the pelvis and very adherent to the surrounding parts. The ovaries and tubes were cystic, the right tube containing some pus. The right ovary and tube were adherent to wall of peritoneum. There was also a mass, the size of a hen's egg, in which were involved right ovary, fimbriated extremity of tube, appendix and head of cecum. The left side was free from adhesions. The left broad ligament was ligated in the usual manner, the right was clasped with clamp, and the tumor removed as quickly as possible. The right ovary and tube were dissected out of the mass and removed. The cecum was closed over with Lembert sutures, all bleeding points were controlled, a piece of omentum was ligated, and the stump of the pedicle was sewed over. The gall bladder was then explored through the median incision and several gallstones were found. The usual incision for cholecystotomy, 4 c.m. long, was made, using right hand inside of peritoneal cavity as a guide. The gall bladder was brought up into the wound, sutured to the peritoneum and surrounding structures by means of silkworm-gut sutures and several

catgut sutures. The gall bladder was aspirated and 4 ounces of bile were drawn off. The gall bladder was incised and 50 stones, the largest the size of a marble, were removed by means of a scoop. A long glass drainage tube was inserted into the gall bladder and packed with iodoform gauze. The patient took the anesthetic well and left the table in good condition.

Postoperative History.—The patient was somewhat slow in convalescing. She was very cholemic and had a train of nerve symptoms marked by decided delusions, yet ultimately made a perfect recovery.

Case 3.—Mrs. S. W., aged 37, entered Albany Hospital January 8, 1903.

Diagnosis.—Pregnancy, gallstones, bicornate uterus.

Family History.—This was negative save that maternal grandmother died, aged 80, of cancer.

Personal History.—In the fall of 1892 she began to feel increased distress about the pelvis, and while regular in her menstruation yet noticed enlargement in the right side of abdomen. It was thought she might be suffering from extrauterine pregnancy. She had had several marked hemorrhages. Menstruation was regular, and an exploration was advised, a positive diagnosis of gallstones also having been made.

Operation.—On Jan. 12, 1903, I did a dilatation, curettement, supravaginal hysterectomy and cholecystotomy. On vaginal examination the left side of the cervix was found badly lacerated and the usual repair was done. A very distinct mass could be felt on the right side. A sound passed well up in the left cornu of uterus, but could not be introduced readily on the right side. The patient was then placed in Trendelenburg position and usual median incision was made. Careful examination now disclosed a 'double uterus, the right containing a fetus of possibly two months' pregnancy. She had previously been curetted, had cervix repaired in another hospital and had had some pelvic peritonitis following. Both sides of the uterus were carefully freed from adhesions. The right ovary and tube were enlarged, with evidence of pyosalpinx present. It was decided to do a supravaginal hysterectomy, after consultation with her husband, and also to remove the appendix. On examination of the gall bladder it was found to contain a number of gallstones, and the usual cholecystotomy was done. A number of stones were removed and the patient made a good recovery from both operations.

Case 4.—Mrs. L. R., aged 30, entered Albany Hospital May 5, 1904.

Diagnosis.—Dermoid cyst of ovary, associated with gallstones.

Family History.—Negative.

Personal History.—There was pain in the right hypochondriac region, severe at times and associated with vomiting.

Operation.—An incision 4 in. long was made in the median

line between the umbilicus and the symphysis. A left ovarian cyst was found and removed in the usual manner; appendectomy was also performed.

The median incision revealed the gall bladder bound to the liver by numerous adhesions. The field of operation was walled off by tampons. On opening the gall bladder there was an escape of mucopurulent material. The gall bladder was mopped out, four stones were removed, the bladder was stitched to the abdominal wound and a glass drainage tube was inserted in the gall bladder, with iodoform gauze packing. This sinus continued and did not close under any line of treatment.

Second Operation.—June 21, 1904, a second operation, anastomosis between gall bladder and duodenum, was done for closure of sinus. The Murphy button was used. A few Lembert sutures were placed around the button to prevent leakage. There was slight soiling of the peritoneum. A glass drainage tube was used.

The patient made an excellent recovery, has since given birth to a healthy child and is in good condition.

Case 5.—Mrs. E. P., aged 38.

History.—Family and past history were negative. For the past two months the patient has suffered considerably with pain in the right side, associated with irregular menstruation. The bowels were constipated; there were no attacks of colic. Micturition was frequent and painful.

Operation.—On Nov. 21, 1903, I did a curettage and ligated hemorrhoids. I also did a suprapubic hysterectomy for fibroid, appendectomy for chronic appendicitis and cholecystotomy for removal of a number of gallstones. Recovery.

Case 6.—Mrs. C. G. Family history negative.

Operation.—On June 2, 1903, I did a left salpingo-oöphorectomy and cholecystotomy, with removal of three large gallstones. The patient recovered nicely.

I have cited these few cases from some which have occurred in my practice to illustrate the difficulty we believe at one time existed, in operating on the gall bladder and like organs, while operating on the pelvis. But while one needs to study carefully regarding the endurance of the patient, yet when the peritoneal cavity is opened, careful examination of these suspected organs should be made and operative intervention resorted to, if gall stones are present. This is in contradiction of many of our beliefs in the past.

28 Eagle Street.