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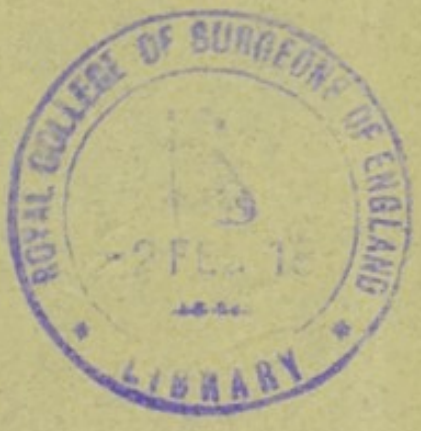

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VAGINAL OVARIOTOMY.[1]

BY CLIFTON E. WING, M. D.

On February 10, 1876, I saw with Dr. Spalding, of Lowell (the physician of the patient), and my partner, Dr. Warner, a lady whose history was as follows: She was thirty-two years old, unmarried, and was never very strong. The menses began at fourteen, were always regular, but accompanied by considerable pain. Twelve years ago, at the age of twenty, after lifting a heavy weight she began to suffer pains in the back and across the lower part of the abdomen, which became much worse during the monthly period and had so increased that for the last six years the patient had been obliged to resort to the use of morphine, and, at times, to etherization, when unwell. Five years ago a local examination showed a retroverted uterus, for which pessaries were tried without much result, and a year later a body was felt in Douglas's cul-de-sac, which was thought at the time, by Dr. H. R. Storer, who saw the patient, to be an ovary. For two years the patient was confined to her room, and part of the time to her bed, by her sufferings, but for the last year or two she has been better, and able to go about a little. She is habitually constipated, and defæcation, even after the use of enemata, is very painful. Micturition frequent, appetite poor, no febrile symptoms, patient emaciated and in a miserable condition.

An elastic but not distinctly fluctuating mass was felt in Douglas's cul-de-sac, pressing the uterus forward towards the pubes. The fundus uteri was turned somewhat backward, but was movable with the sound. The latter entered to the normal depth. With the patient under ether the tumor could not be pressed from its position, and previous efforts in the same direction had failed. Examination per rectum showed that the mass pressed the bowel against the sacrum, and explained the constipation and painful defæcation.

An aspirator needle was passed into the mass from the vagina, but only a small amount of dark, bloody fluid was withdrawn. Dr. E. G. Cutler kindly examined this and reported as follows: "The fluid (about two drachms in quantity) contained a large percentage of albumen. Under the microscope many red blood corpuscles were seen which had

[1] Read before the Suffolk District Medical Society, September 30, 1876.

lost their characteristic shape and had become irregularly crenated. The surfaces of many showed a few spots not unlike small globules of fat[?]. In addition were seen numerous granular cells in various stages of fatty degeneration, varying in size from that of a white corpuscle to double that size. Hæmatin crystals; no others. Diagnosis of fluid, old hæmorrhagic effusion."

The tapping was not followed by any symptoms.

March 30th. The tumor remaining the same, the aspirator was again used, and this time several ounces of the same fluid were removed, and the mass much diminished in size. This second tapping was not followed by improvement; on the contrary, some time afterwards the patient began having occasional slight chills followed by fever, nausea, and headaches; in fact, a mild septicæmia. She continued to lose strength and appetite, though not confined to bed.

When next seen, April 19th, an examination showed the mass behind the uterus to be as large as ever, and more tense and cyst-like. Upon passing an exploring needle from the vagina, as before, a few drops of exceedingly offensive matter escaped. It was evident that the fluid must be thoroughly evacuated, whether it came from an old hæmatocele or from a hæmorrhagic ovarian cyst, one of which seemed to be present.

With the aid of Sims's speculum and position, the parts being well drawn down towards the vulva with tenacula, and care being taken to avoid wounding the rectum, an opening was made through the upper part of the vagina and the peritoneum into Douglas's cul-de-sac. Passing my finger through this I distinctly made out a small ovarian cyst, about the size of an orange, fixed in the cul-de-sac by some loose adhesions which easily gave way before my finger. The opening having been enlarged, the cyst was seized with strong forceps, opened and evacuated, then twisted to diminish its size, and pulled through into the vagina. There was no proper pedicle, but the uterus, tipping backward, allowed the broad ligament with the Fallopian tube to come well into the vagina. I intended here to apply a ligature and cut away the cyst, but Dr. Warner, in making a digital examination, finding the attachments loose, attempted enucleation with his finger, succeeded in separating the tumor, and brought it away.

There was some bleeding, which soon ceased entirely, and as the uterus went forward the broad ligament slipped back into the abdominal cavity. No ligature whatever was used, but, a coil of small intestine appearing at the opening, I inserted three silk sutures and closed the wound sufficiently to prevent hernia, but left room to pass a catheter, should there be any collection to wash out. The patient was then put to bed.

April 20th. Patient came out of the ether well, had no shock, and

passed a good night with the aid of morphine. Reports no more pain than after the previous tapping. No bleeding, some slight chills, no nausea. Taking mild nourishment. Occasional shooting pains in pelvic region. Pulse 116 and good.

April 21st. Pulse 114, temperature 100¾° in axilla. Some abdominal distention and pain, and considerable tenderness, but patient moves limbs without much increase of pain. Thirsty, no chills, but nurse reports sweating. Tongue coated, and brown at edges. No appetite, but takes her food. Washed out cul-de-sac, using double catheter and getting away an ounce of fœtid fluid.

April 22d. Pulse 96, temperature 99½°, respiration 18. "Feeling better." Washed out more fœtid fluid. Menses appeared to-day, one week early.

April 23d. Pulse 96, temperature 100¾°. Poor night, with pain in lower abdomen, but better to-day.

April 24th. Pulse 96, temperature 99½°. Patient reports herself nicely. In washing out cul-de-sac, which is done daily, some sloughy tissue came away to-day.

April 25th. Pulse and temperature normal.

April 29th. Bowels have been moved twice by enemata. Pure pus came from wound, which is granulating. Removed the sutures. Catheterization of the bladder, for a time necessary, now dispensed with. To have vaginal injections in place of the washing out with catheter.

May 6th. Touched granulations with caustic.

May 18th. Wound closed. Patient walking about the house, and dismissed.

Her rapid recovery was due in great measure to careful watching and faithful attendance on the part of Dr. Spalding after the operation.

I met the lady, for the first time since May, a day or two ago. She was no longer using morphine, and was increasing in weight and strength. The menses had been regular since the operation except within the last two months, when the flow had appeared every three weeks. This she attributed to the fact that, through illness in the family, the cares of the household had devolved upon her, and, as she expressed it, she had been obliged to be on her feet and running up and down stairs from morning until night. To the same cause she attributed a backache which she had had for a week or more, having been previously free from it.

Vaginal ovariotomy is an operation of recent date, having been first done by Thomas, of New York, who, February 6, 1870, removed a small ovarian tumor, tapping several cysts in so doing. The case was published in *The American Journal of the Medical Sciences*, April, 1870, and is quoted in full in Thomas's Diseases of Women, edition of 1875,

where the author says of the operation,[1] "It is fully as easy of performance as abdominal ovariotomy, is evidently attended by much less danger, holds out to the patient the opportunity of avoiding many weary months of suspense in anticipation of that more grave procedure, is equally applicable to multilocular and to unilocular cysts, gives abundant facility for securing the pedicle, and is, so far as my knowledge and experience go, defensible as a surgical procedure against all but theoretical objections." "It is not my belief that the scope of this plan of performing ovariotomy will ever be very great, but I think in cysts of small size, which are unattached, it will offer a valuable resource for the avoidance of years of mental suffering while the disease is progressing, and of the capital operation of abdominal ovariotomy in the end, with all its attendant dangers and uncertainties. Even in a doubtful case, vaginal ovariotomy may be resorted to as a tentative measure, which, in the event of failure from the attachment of the cyst, would in all probability be recovered from." [2]

Dr. Peaslee, who was present at the operation by Thomas, did not form so favorable an opinion, and in his treatise on Ovarian Tumors writes as follows: "Upon purely surgical grounds, vaginal ovariotomy is, I think, hardly defensible, since —

"(1.) It is practicable only in case of a very small cyst and while it gives no special inconvenience to justify interference in any way.

"(2.) It is more difficult than the ordinary operation of ovariotomy.

"(3.) It is performed before the cyst has acquired a distinct pedicle, and therefore the ligature cannot be applied with precision. If there be two or three cysts in the mass, especially if the case is one of polycyst, one or more of them will probably be left intact to undergo subsequent development, and it is impossible to determine beforehand that a given tumor is a monocyst.

"(4.) The operation is certainly not less dangerous than ovariotomy performed in the usual way while the tumor is small and without adhesion. I think it decidedly more so." [3]

Gilmore, of Mobile, operated successfully September 6, 1873, reporting the case in the New Orleans *Medical and Surgical Journal* of November, 1873. The tumor was of the size of an orange. He thinks Peaslee does injustice to the operation, and considers the vaginal operation safer than the abdominal, for the reason that the vaginal incision is made through tissues highly vitalized, which heal more readily than the abdominal incision; that it avoids fat and tendons, and gives better drainage; and also that "every practical surgeon knows that the more remote an incision into the abdominal cavity is from the diaphragm, the less the danger from acute peritonitis." Indeed, he formed so favorable an opinion of the operation that he proposed in the future, in case of a suspected unilocular cyst low down, to lay open the vagina, tap

[1] Page 738. [2] Page 735. [3] Page 321.

the cyst, and, if possible, extract in this way, holding the abdominal incision in abeyance.

Battey, of Georgia, March 30, 1874, removed a small ovarian tumor by the vaginal operation, the patient recovering,[1] and had, up to October, 1875, operated in this way, in doing the so-called "normal ovariotomy," nine times upon eight patients.[2] His first operation of normal ovariotomy was done by the abdominal incision, which he has since abandoned for the vaginal. He has had two fatal cases.

Perhaps as striking a case as any yet reported is that of Davis, of Wilkesbarre, Penn., who, in 1872, successfully removed an ovarian cyst weighing nine pounds through the vagina. In rupturing adhesions, which were abundant, his hand was passed high up into the peritoneal cavity, the sac extending several inches above the umbilicus, and forming a tumor about the size of a pregnant uterus at the seventh month of utero-gestation.[3]

This shows that a large cyst may, even if adherent, be removed in this way, yet it is doubtful if any one who has witnessed the difficulties often encountered in separating adhesions when the ovariotomist has the advantage of a large abdominal opening, and can plainly see what he is doing, would wish to attempt a repetition of the operation. It is evident that adhesions might be separated through the large abdominal incision which would prevent the completion of the operation through the vagina, and adhesions are often met with when least expected.

The question of the advisability of the vaginal operation for ovarian tumors would seem to be limited to the cases of very small ones, particularly such as have not risen out of the pelvis, but this is the stage in which, as a rule, as Dr. Peaslee remarks, "they give no special inconvenience to justify interference in any way." If the tumor causes symptoms by its pressure it can, unless adherent, as in our case, be pressed up out of the pelvis, and be kept there by a properly fitted supporter, and the patient can be made comfortable. The majority of patients know nothing of the presence of the tumor while it is in this stage, and escape "mental suffering while the disease is progressing" unless some officious attendant tells of the discovery he has made.

The vaginal operation then is done when the patient is slightly, if at all incommoded by the growth, appears to her friends in good health, and would perhaps remain comfortable for several years; while, on the contrary, abdominal ovariotomy is performed at a time when the patient feels its necessity, and is anxious for relief from her constantly increasing sufferings, with death the only result if the operation is not resorted to.

[1] Thomas, Diseases of Women, page 737.

[2] Battey's Operation. By Drs. Yandell and McClellan. American Practitioner, October, 1875.

[3] Transactions of the Pennsylvania Medical Society, referred to by Thomas in American Journal of Medical Sciences, July, 1876.

If the former operation were much less dangerous, as some think, we should be justified in urging it upon the patient even when she is in the enjoyment of fair health, but this is by no means established. The reported cases are too few in number to settle the question. In our case suppuration of the cyst and the attendant condition of blood-poisoning made operative measures imperative, and after the peritoneum was opened, before which a positive diagnosis of ovarian cyst was impossible, the simpler method seemed to be to remove the ovary through the opening made.

The vaginal operation is certainly not easier, and complications are likely to prove more troublesome than with the abdominal opening. I think Dr. Thomas himself will now be ready to concede this, since, in his second attempt at vaginal ovariotomy, made to remove a large and tender ovary, recently related at a medical meeting in New York, he failed to get into the peritoneal cavity, the rectum and the posterior wall of the uterus being glued together by lymph. In attempting to separate them he broke through into the rectum, and finally, giving up the vaginal operation and closing the rectal wound with sutures, he removed the ovary by the abdominal operation. In another attempt to open the peritoneum from the vagina, at which I was present, the operator, one of the most distinguished surgeons in the country, failed completely and was obliged to give up the attempt, although ascites was present, which theoretically should distend Douglas's cul-de-sac.

The trouble anticipated by Dr. Peaslee in regard to the pedicle does not seem to have been met with as yet. In our case there was no proper pedicle, yet the broad ligament was brought so far into the vagina that it could have been tied without great difficulty.

The fact that the intestine appeared at the vaginal cut is interesting, as lately some high authorities have held that the small intestine is never found in Douglas's cul-de-sac.

Vaginal ovariotomy has not been done as often for the removal of tumors as in the performance of "Battey's operation" or "normal ovariotomy," that is, "the removal of the ovaries," not necessarily diseased, "for the purpose of bringing about the change of life," as proposed by Dr. Battey in cases where this is deemed desirable. The same terms by common usage are applied to cases where the ovary is removed for neuralgia, etc., even when one only is taken away. It is a procedure the propriety of which is still "sub judice," and involving, as it does where both ovaries are removed, the unsexing of the woman, it will not be approved of by the profession generally unless it show unquestionable good results. In New York, where the operation has been done a number of times, the results, according to Dr. Mundé,[1] are not such as will probably lead to its abuse by repetition. It must be considered in the light of a capital operation. In one fourth of the cases of which I

[1] American Journal of Obstetrics, April, 1876.

know, where the operation has been done, the patients have died, and recovery from the operation by no means implies that the patient was benefited. Among the reported cases a few brilliant results are to be found, and in some instances where death has resulted, after reading the histories of the patients the procedure seems justifiable, but in other cases the propriety of the operation may well be questioned. I do not believe Dr. Battey himself would have operated in all cases where his operation has been done.

In several instances where the ovary has been removed for the relief of pain referred to it, the patient has received no benefit at all, yet where both ovaries were removed she has been unsexed. One cannot but think it a serious matter to submit a patient to such an operation while our diagnoses and prognoses of the so-called "ovarian neuralgias" are as uncertain as at present. Everybody having experience in female diseases can call to mind cases where the ovary has been thought at fault until a correct diagnosis placed the trouble elsewhere. At best our knowledge is far from complete. To instance the looseness of views upon the subject, one gentleman in the report of a case of normal ovariotomy writes as follows: —

"I do not believe that the removal of the ovaries could in any instance be resorted to with an expectation that the menstrual function would certainly be abolished, nor do I believe that normal ovariotomy would cure hysteria any more than ablation of the testicles would cure spermatorrhœa. . . . . Yet if I were dealing with an ulcer of the stomach or gastritis due to the menstrual molimen fixed in the solar plexus that could not be dislodged by remedies, and life were seriously jeopardized, I would entertain thoughts of normal ovariotomy."

It is to be hoped that this proposed method of treating gastric ulcers will not become popular.

In one case a surgeon removed both ovaries for what he was positive was "pure ovarian neuralgia." After the patient recovered from the operation she complained of the same pains, in fact declared them identical with those which she had had before. The gentleman now considered them "unquestionably hysterical," which might be termed a "diagnosis by *excision*."

Anxiety on the part of the specialist to perform great or rare operations whenever a possible chance offers is unfortunate, as nothing tends more to produce a feeling of distrust of the specialty itself among the members of the profession. "It must be conceded that to obviate by judicious treatment the necessity for an operation is more meritorious than to perform it well when required,"[1] and the fact that we are obliged in certain cases to resort to the removal of the ovaries to help our patients is, as pointedly remarked by one gentleman, rather a reproach to medicine.

[1] Allingham on the Diseases of the Rectum, Preface.