

Coeliotomy for myoma of the uterus : hysteromyomectomy : infection by Bacterium coli commune / by Hunter Robb and Albert A. Ghiskey.

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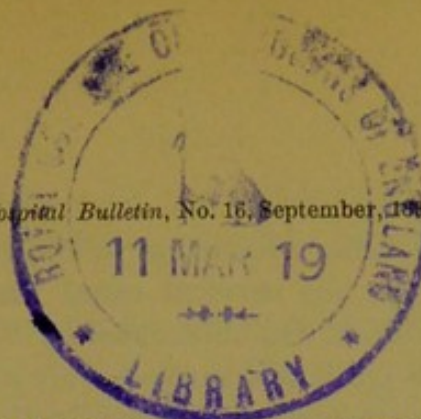
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COELIOTOMY FOR MYOMA OF THE UTERUS. HYSTEROMYOMECTIONY. INFECTION BY BACTERIUM COLI COMMUNE.

By HUNTER ROBB, M. D., *Resident Gynecologist*, and ALBERT A. GHRISKEY, M. D., *Assistant Gynecologist to the Johns Hopkins Hospital*.

On the 7th of May last, S. J., colored, 34 years old, and single, entered the gynecological ward of the Johns Hopkins Hospital, in the service of Dr. H. A. Kelly.

On admission the following observations were recorded: Patient well nourished, somewhat anaemic. Date of the last menstrual period, April 12th. Menstrual flow regular, moderate in amount; no history of hemorrhages. She has had leucorrhoeal discharges for the past two years, most marked immediately following the menstrual period. For the past year has complained of painful micturition and "bearing-down" pain in the lower zone of the abdomen; also complains of a stinging, burning pain in the left ovarian region, and across the small of the back; this is increased on exertion.

Examination per vaginam reveals a nodular myomatous uterus about the size of an adult's head, extending from the pelvis to above the umbilicus. Temperature and pulse normal. Urine clear with a faint trace of albumen and some doubtful casts.

Operation May 9th, under chloroform narcosis. Hysteromyomectomy performed by Dr. Kelly's method.

An incision 6 cm. long was made in the median line, through the moderately thick abdominal walls. The tumor mass was exposed and delivered through the lengthened incision. After tying off the broad ligaments on either side, and down to the base of the mass, a rubber ligature was thrown around the uterine pedicle below.

The mass was developed so low in the uterus that it would have been impossible to elevate it sufficiently to treat this case extra-peritoneally with clamp or ligature. The mass above the provi-

sional rubber ligature being cut away, and the portions of the remaining pedicle being trimmed so as to allow the approximation of the opposite faces, the cervical canal was cauterized, and the raw face of the pedicle was obliterated by buried interrupted cat-gut sutures. The peritoneal surfaces were approximated by silkworm gut, and the pedicle suspended in the lower angle of the wound. A drainage tube was put in above the pedicle; there was no hemorrhage.

The first dressing of the tube was made the next day, May 10th, 24 hours after the operation. Notes made were: Cotton over the tube slightly moistened, the plug in the tube thoroughly saturated with dark clotted blood. Six pledgets of cotton used in cleaning the tube, the last scarcely moistened. The tube was therefore removed.

Cultures were made and a cover-slip preparation studied. The following day the culture tubes showed profuse growths resembling staphylococcus pyogenes albus. The temperature by the mouth on the day after operation was 101.2° F.; by the rectum, 102.3° F. The temperature after the removal of the tube on the day after operation went up in the evening to 102.6° F. by the rectum; 101.5° F. by the mouth. The pulse became rapid, and at eleven o'clock the same evening it was between 140 and 150, although the temperature declined, going down to 99.4° F. by the mouth, and 101.4° F. by the rectum.

Stimulants were given hypodermically, and an attempt made to open the bowels by enemas, and also by salts administered by the mouth. Two or three sutures in the lower angle of the wound near the track of the drainage tube were cut and removed, as the abdomen at this time was found to be distended and hard. After opening the peritoneal cavity, and making some slight pressure, several drachms of a bloody brick-colored fluid exuded. Upon inserting the finger through the incision several bands of adhesions were felt on the left side between the intestines and pedicle. These were easily separated. The intestines were noted to be much distended. At no other place could any adhesions be discovered. A drainage tube was again inserted and the usual dressings applied. This operation was performed without anaesthesia.

The pulse immediately after this increased somewhat in strength, but hourly records showed it to be fluctuating and irregular, going as high as 156. She then began to have some nausea, which increased so much that it was impossible to administer

anything by the mouth. When the tube was inserted, 10 per cent. iodoform gauze was used in the tube instead of the ordinary sterilized gauze.

The tube was dressed again the next day, at 3.35 p. m., 27½ hours after the first dressing, or 51½ hours after the operation. The cotton over the tube was scarcely moistened; the plug in the tube was moist and discolored with blood. Five pledgets of cotton were used to clean the tube. The usual cultures were made. The condition of the patient at this time seemed somewhat better; the abdomen not so distended, and the nausea diminished; but the pulse was still quick, 150. The temperature on this day fluctuated considerably; the mouth temperature was as low as 98.8°, and at the same time the rectal temperature was 102.6°. The usual stimulants were continued, and rectal enemas used to induce the bowels to move. She also complained this day of considerable pain in the lower portion of the abdomen, and also of some pain in the epigastric region. After the bowels were slightly moved, this was very much diminished. The vomiting increased in amount, and occurred at more frequent intervals.

The next day the tube was dressed at 3.40 p. m., 24 hours after the second dressing. The usual cultures were made. Cultures from the first dressing now showed better, and numerous *colon bacilli* were recognised, and not *staphylococcus pyogenes albus*, as at first surmised. The notes taken at this time were: Dressing over tube dry, plug in lower portion of tube wet with slightly colored bloody fluid. Tube cleaned with four pledgets of cotton; tube raised and turned. Abdomen much distended. Great tendency to stupor, nausea not so frequent, but there were one or two bad attacks. Pulse to-day full, regular and quick. Usual stimulants given hypodermically and by mouth, as she could retain them. The temperature on this day, by the mouth, 98.5° in the morning, to 103.3° at 3.55 a. m.; and by the rectum, the temperature in the morning was 104.6°, and at 3.55 a. m. was 104.3°, at which time she died in collapse on the 4th day.

Autopsy of case made five hours after death.

The following notes were recorded at the autopsy performed in the Pathological Laboratory. The autopsy is necessarily imperfect, owing to the conditions under which it was made.

Anatomical Diagnosis. Diphtheritic enteritis. Oedema of the lungs. Peritonitis. Operation wound of abdominal walls. Hys-

terectomy. The small intestines are enormously distended and the pelvis contains adherent loops of the ileum. There is some bloody fluid between the intestinal folds. There are slight adhesions between the intestines in the upper part of the abdomen. In the posterior part of the abdominal cavity there is some bloody exudation. At the point of contact, the intestines are covered with a small amount of fibrin. The peritoneal surface is in places intensely injected and there are some small ecchymoses. In the pelvis there is a small amount of bloody fluid. Portions of the tubes, the ovaries and a large part of the uterus have been removed. In the stump of the uterus there is a large blood clot. The ends of the tubes are sloughy and bloody. The intestines are adherent to these structures.

The lungs are oedematous, the heart is soft and flabby. The liver is soft and of a pale brown color, and the gall bladder is distended with thin, watery bile. The kidneys are pale. In the lower portion of the ileum there is an area of intense congestion. At this point there is some superficial necrosis of the mucous membrane, confined to the edges of the valvulae conniventes. The large intestines and the rectum are normal.

Cultures made from the liver, spleen and kidneys gave bacilli—apparently colon bacilli. The cultures taken from the peritoneal cavity all gave negative results.

This case is of peculiar interest on account of the presence of the *bacterium coli commune* in the peritoneal cavity. It was found in all the dressings of the drainage tube, and also in the liver, kidney, spleen and bile at the autopsy. That these organisms were the colon bacilli was shown not only from their morphology but from their characteristic growth in cultures. Diphtheritic enteritis occurring as a complication of the condition, is also of much interest.

We are not able to decide positively that this diphtheritic enteritis was not due to douches of bichloride of mercury, one being given on the morning of the operation, and one immediately previous to the operation. About a half-litre of a one to one-thousand watery solution of corrosive sublimate was used each time, and simply allowed to discharge itself. The enteritis which existed resembled very closely that produced by corrosive sublimate.

We have desired especially to emphasise the discovery of the *bacterium coli commune* in the peritoneal cavity in pure culture, with extensive enteritis, without marked peritonitis.