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Contributors

Thornton, J. Knowsley.
Royal College of Surgeons of England

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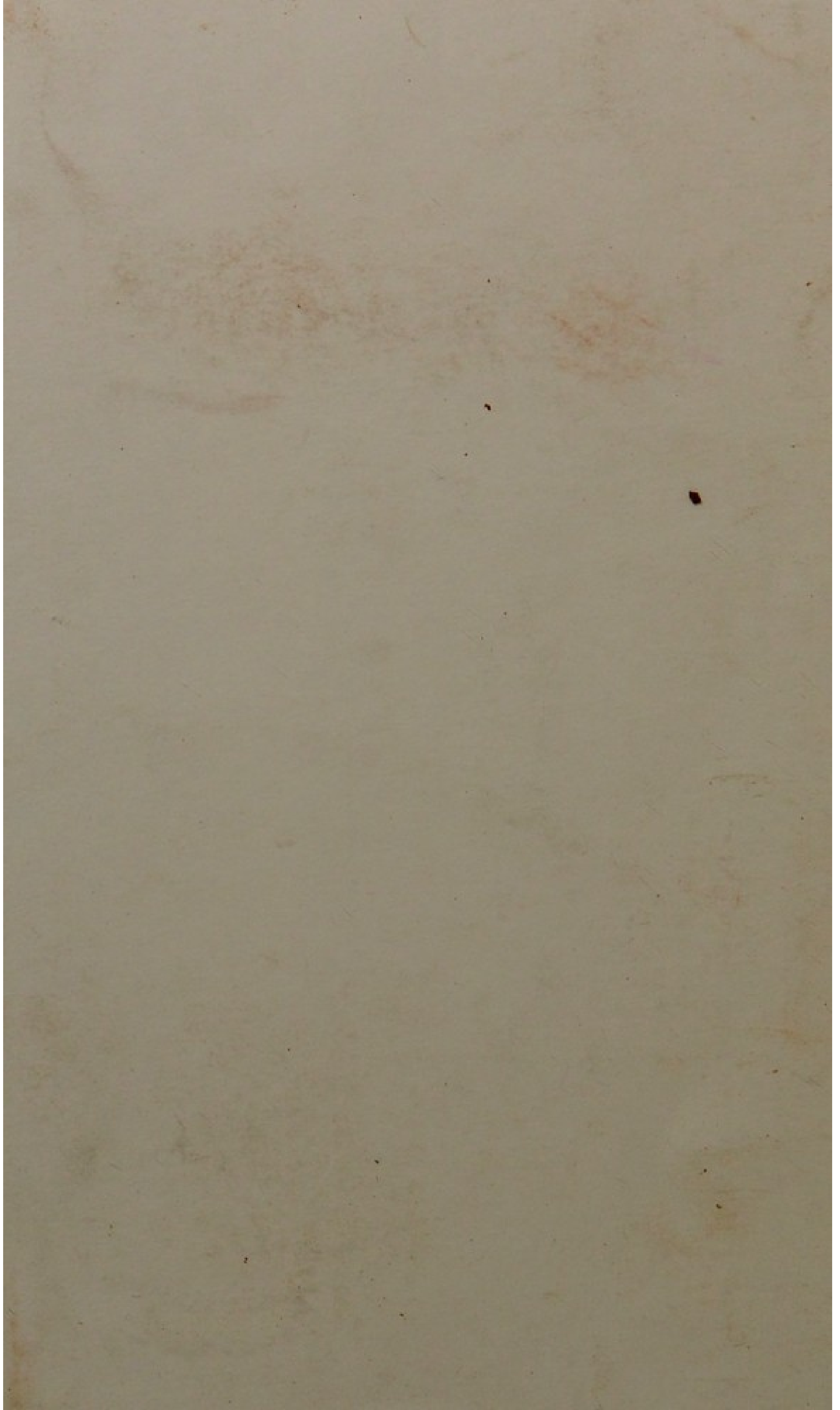

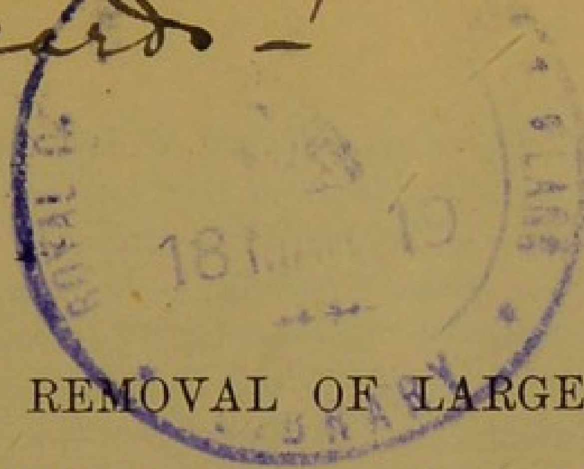

REMOVAL OF LARGE FIBRO-CYSTIC TUMOUR OF THE UTERUS: RECOVERY.

By J. KNOWSLEY THORNTON, M.B. C.M.,
Surgeon to the Samaritan Free Hospital.

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FIBRO-CYSTIC tumours of the uterus are so rare, and their successful surgical treatment is so much more rare, that I make no apology for publishing a single case of the kind.

H. E. T., aged forty-six, married, and mother of two children, was first seen at the Samaritan Hospital four years back. Mr. Spencer Wells also saw her, and agreed with me in the opinion that she had a fibroid tumour of the uterus. It was of only moderate size, and we both strongly advised her not to think of any operative interference. She had noticed some increase of size a year or two before she came to the Samaritan. She returned twice after this first visit, and on each occasion was seen both by Mr. Wells and myself, and received the same advice, the tumour meanwhile growing slowly.

In November, 1878, she found her way to the out-patient department, and was seen by my friend and colleague Dr. Champneys, who brought her to my wards for one of our Friday consultations. The tumour had now enlarged

enormously, and there was a sort of doubtful fluctuation. Mr. Wells and myself independently, and not knowing that we had seen the case before, both thought it was one of those rare tumours of the broad ligament named by Virchow "Fibroma molluscum." She was still advised not to think of operation unless increase of size or some urgent symptoms should render interference absolutely necessary.

In June, Dr. Champneys again sent her to me with a note as to the great increase of size, and a suggestion that an exploratory operation would be advisable. I admitted her as an in-patient, and asked Mr. Wells to see her again. Dr. Champneys had said in his note, "She has got much larger, principally, I think, from ascitic fluid." Mr. Wells quite agreed with Dr. Champneys and myself as to the advisability of an exploratory incision, and we failed to decide whether the fluid was in the peritoneum or in a very thin cyst. The fluctuation was indistinct, and the question arose as to whether a soft semi-solid tumour had ruptured; but there had been no symptom of such an event.

Menstruation had been regular, and her general health fair until the rapid increase in size; since this began she had lost flesh fast, and at the time of admission was extremely emaciated, and had a rapid, wiry, and weak pulse, and no appetite.

On June 30, at 9.30 a.m, she was placed under the influence of bichloride of methylene by Mr. Doran, and, assisted by Mr. Meredith, I commenced an exploratory operation. The first incision, which was about four inches long, exposed a very soft reddish tumour, clearly uterine. I passed in my hand, and found a very large pedicle at the left upper angle of a somewhat large fibroid uterus; both ovaries healthy, and in their normal situation. Feeling certain that it was possible to remove the tumour, I extended my incision to seven inches, and after separating a large patch of adherent omentum, which required several fine carbolised silk ligatures, I found behind the solid anterior portion of the tumour an enormous cyst with thin walls, through which I could see a dark bloody fluid. Having emptied this cyst with the trocar,

I found that the pelvic portions of the tumour were chiefly cystic. There were many cysts, all much of a size, and so thin and universally adherent that I was obliged to break them up *in situ*, much cyst-contents and blood pouring over the uterus, ovaries, and rectum. Having cleared the pelvis and separated some parietal and intestinal adhesions, I turned the tumour over to the left side and downwards, so that Mr. Meredith supported it on the left thigh of the patient. I was now able to see what I had already examined by touch—a thick vascular pedicle springing from the back and left angle of the fundus uteri, so that it was possible to include the whole in the largest Spencer Wells clamp without including the left tube or ovary. I transfixed it with a strong carbolised whipcord ligature, and applied a temporary clamp, and cut the tumour away in order to be able to see more exactly where the permanent clamp should be applied. Having put on the permanent clamp, I tightened it as the temporary clamp was removed, and the whipcord cut away by Mr. Meredith. Not a drop of blood was lost during this part of the operation, except what was in the tumour, and Mr. Doran remarked on the immediate improvement in the condition of the patient when the tumour circulation was thoroughly cut off by the first clamp and ligature. A good deal of sponging was necessary, and some troublesome oozing was still going on from the parietal and omental adhesions high up in the abdomen when I closed the wound.

I hesitated at first whether to use a glass tube for drainage, but feeling confident as to my antiseptic precautions during the operation, and thinking that discharge of the serum and blood would further weaken the patient, and also that it would be very difficult to keep all aseptic if I had a tube opening beside the clamp with such a large stump, I decided to entirely close the peritoneum at once. I dressed as usual with carbolised gauze, taking care that the surface next the wound was well moistened with the lotion before I applied it; because dust which may have settled on the gauze just before its application has not had time to be acted upon by the carbolic acid in the gauze, and may hence be applied

in a septic condition directly to the wound by the very dressing which we use to avoid septicity.

The patient was placed in bed at five minutes after eleven, one hour and thirty-five minutes from the time she lay down on the operating-table.

She was much collapsed, cold, and blue; axillary temperature 97·8°; but she rallied rapidly, and at 9 p.m. was very comfortable, perspiring well; temperature 100·8°, pulse 120, respirations 20. During the first two days progress was satisfactory: pulse quiet and of fair strength; flatus passed well, and there was plenty of urine. Menstruation commenced on the second day, and in the afternoon, fifty-four hours after the operation, temperature began to rise and the pulse varied from 108 to 120; at 9 p.m. the temperature was 103·4°, but as she was perspiring well and there was no unfavourable symptom except the restlessness, and as I did not wish to check the menstrual flow, I did not put on the ice-water cap, as I generally do with such a temperature. At four the next morning she had a slight rigor, the temperature remaining over 103°. In the middle of the day the pulse was again 120, respiration shallow and rapid, so the ice-water cap was put on, with the temperature at 104°. It at once began to fall, with a proportionate decrease in the rate of pulse and respiration. On the evening of the sixth day the temperature was normal, and the cap was removed; but at 8.30 p.m. on the seventh day it was 102°, and the cap was put on again and kept on till the ninth day, when it was finally removed. During this time I dressed the wound daily under the spray, and was somewhat anxious as to its asepticity, as the gauze about the clamp had a sour smell, and I was afraid some cause of putrefaction in the clamp-hinge might have escaped the carbolic acid when the clamp was cleaned. On the third day I detected a considerable quantity of fluid in the recto-vaginal pouch, which bulged much in the vagina, and I have no doubt that the reabsorption of this bloody serum was the cause of the high temperature, and I regard the case as an example of the fever described by Billroth and attributed to reabsorption

of effused fluids. The bowels were cleared by enema on the ninth day, and on the eighteenth day I removed the clamp, with slight hæmorrhage from the centre of the pedicle stump, which was easily stopped by solid perchloride of iron. She was up on the couch on the twenty-fifth day, and walking about four days later, but remained in the hospital till the forty-sixth day after operation, as I was anxious she should go straight from the hospital to a convalescent home. The solid part of the tumour weighed after removal 20 lbs. 7 oz., and there were 41½ pints of fluid, or in all 62 lbs. The solid portions of the tumour were in part the ordinary fibro-myomatous tissue much infiltrated with serum, which in some places formed false cysts of considerable size; but the larger and more truly cystic portion of the tumour was a cysto-sarcoma, the solid portions being rich in large fleshy multinuclear cells with quantities of immature round and oval granular cells. There was one very large cyst with thin walls, covered externally with peritoneum, and internally with small flat nucleated cells, more like those found lining extra-ovarian cysts than those in true ovarian tumours. Besides this large cyst there were many smaller cysts grouped together much as they are in a multilocular ovarian tumour. The main mass of these filled up the pelvis. In some places their walls were as thin as paper, but even then the muscular element could be traced, mixed with the larger cells. I am indebted to my friend Mr. Meredith for some microscopical preparations and drawings of this part of the tumour, which have aided me much in forming an opinion as to the exact nature of the growth.

I suspect the term "cysto-sarcoma of the uterus" would more correctly describe all these cases than the older name I have used above. It is noteworthy that they usually arise in patients who have been for some years the subject of fibroid tumour of the uterus: suddenly there is a rapid increase of growth with formation of cysts; a degeneration in the growth, or rather a change from homœoplasia to heteroplasia. There are too few cases of which the after-history has been recorded for us to determine whether

they follow the usual law of heterologous growths and recur.

I used the clamp in this case because I have seen it answer remarkably well for the pedicle of uterine tumours in the hands of Mr. Spencer Wells, and I have not found the silk ligature answer so well when dealing with a large solid pedicle of uterine tissue. I still, however, much prefer the ligature for the ovarian pedicle, and increased experience has fully confirmed the views on this subject published in my paper in the *British Medical Journal.**

From what I have seen of operations for the removal of large uterine fibroids and fibro-cysts, I believe the stump is apt to pour out a considerable quantity of serum when treated by the ligature, and in very thick pedicles it is quite likely that as the tissues shrink a certain amount of blood escapes with the serum. It therefore becomes important to consider whether it is best to keep the pedicle outside, or to prevent exudation by the use of the actual cautery. My experience of the cautery has been very small, but I have not been favourably impressed with its use in other hands, and I certainly feel more comfortable when I know that the pedicle is secured either by clamp or ligature. I cannot, however, regard any extra-peritoneal method as altogether satisfactory, and I think that with increased experience we may find that some combination of ligature and suture of flaps over the raw surface of the pedicle will answer best. In the case recorded above, any increase of the quantity of effused fluid in the peritoneum would probably have increased and prolonged the pyrexia, and might have thus endangered the life of the patient.

I may mention that this patient was nourished during the first three days entirely by enemata of strong beef-tea (three ounces every two hours); a little weak brandy-and-water being given by the mouth occasionally. The enemata were continued up to the seventh day, and then gradually

* "The Silk Ligature as a Method of Securing the Ovarian Pedicle: its Advantages and Disadvantages; with Brief Notes of its Results in Thirty-eight Cases" (*Brit. Med. Jour.*, January 26, 1878).

discontinued as she began to take more nourishment by the mouth.

I frequently employ enemata in the same way after ovariotomy, commencing in some cases almost immediately the patient has recovered consciousness. Laudanum or wine is added as required. If the patient is very weak, a tablespoonful of port wine in each or every second enema is very useful, and is preferable to brandy, which soon renders the rectum irritable. I am indebted to my colleague Dr. Day for this suggestion, and have found it a most valuable one. When enemata are given in this way the nurse passes the female pipe of an ordinary Higginson's syringe into the rectum ten minutes before each injection, and allows it to remain there till the fresh injection is given, so that refuse of beef-tea and flatus pass freely away before the fresh supply of nutriment is given.

One word as to the diagnosis in this case. In the early stages it was clear enough: an ordinary fibroid outgrowth from the uterus. Then came the cyst development, with general infiltration of serum, leading to the opinion that it was a fibroma molluscum. This was clinically correct, though not histologically so. It was a fibroma infiltrated with serum; and a fibroma molluscum is merely a peculiar soft kind of connective and fibrous tissue of which the individual elements as well as the lymph-vessels and spaces are distended with serum. When seen shortly before operation, distension had become so great that accurate diagnosis was no longer possible.

The patient is now at the convalescent home, and I hear from her husband that she is quite well and rapidly regaining her strength.

PARK STREET, GROSVENOR SQUARE.

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