

**Abdominal sections in the Western Infirmary from 1894 till 1897 / with remarks by Murdoch Cameron, M.D., F.F.P.S.G., Regius Professor of Midwifery in the University of Glasgow; Physician for Diseases of Women, Western Infirmary.**

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1894 TILL 1897, WITH REMARKS  
BY MURDOCH CAMERON, M.D.,  
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## ABDOMINAL SECTIONS IN THE WESTERN INFIRMARY FROM 1894 TILL 1897,

WITH REMARKS BY

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It is only within recent years, and even within the memory of many men in active practice that laparotomy has been developed for the relief of women suffering from disease of the uterus and its appendages. We are proud to know that the case of ovariectomy performed and recorded by Dr. Robert Houston of Glasgow was the first on record, and regret that so many years elapsed before anything further was done.

In 1731 Willins, of Basle, mentioned the operation, and in 1762 Hunter advised the making of a small incision, tapping, securing the pedicle, and removal of the cyst as a proper method of treatment. Chambon, in 1798, advised the removal of diseased ovaries, and Bell included the practicability of ovariectomy in his lectures. Some writers ignore the claims of Houston, and give the credit to Dr. M'Dowall, of Kentucky, who in 1809 successfully removed a large ovarian cyst. It is interesting to know that M'Dowall was a pupil of Bell's.

At long intervals cases were recorded with varying results by Lizars, Clay, and others, but the operation received its greatest impulse from the publication of Sir Spencer Wells' papers in 1864.

As a student, I can remember how Lister and other surgeons dreaded the operation, but since then, step by step, experience has overcome difficulties, until now each of the various stages



in the procedure is founded upon a sound basis. The use of the clamp and the cautery has been totally discarded for ligature of the pedicle, whilst the intra-peritoneal treatment of the stump has entirely replaced the extra-peritoneal method. In connection with sutures and pedicles, it may be mentioned that a very curious case, not cited here, was seen. The patient, who had undergone Caesarean section three years previously, complained of bladder irritation. On examination three calculi were found suspended from the anterior wall of the bladder. Upon removal of these it was found that each consisted of phosphatic deposit upon silk sutures which had made their way into the bladder, but still retained hold of its wall. A year later a fourth calculus was removed, with its silk pedicle, from the same patient. She now enjoys good health.

At the present time, notwithstanding the wonderful results secured by asepsis and antisepsis, opinion still varies as to the best method of closing the abdominal wound, and some operators tend to advocate operation per vaginam instead of abdominal incision. On this point I may be excused if I again refer to Dr. Houston, as he in his ovariectomy used three sutures at equal distances in closing the abdominal wound, whilst much later we read of the use of compresses and a bandage to secure the wound. It was only in 1851 that complete closure of the wound was advocated by Baker Brown, but many still dreaded to puncture the peritoneum, and so carefully avoided its inclusion in the suture. Sir Spencer Wells, in his fourth ovariectomy, made a curious but important discovery. The patient died, but the post-mortem examination revealed the fact that the needles which had been used to close the wound instead of sutures, and did not include the peritoneum, had left their impress upon the intestines, which were adherent. Through experiments upon dogs he found that if peritoneum was brought to peritoneum, complete union of the peritoneal layer was secured, but that if not included the peritoneum retracted, and left the inner surface of the abdominal wound exposed, with the result that adhesions with the intestines took place.

Another great advance was the use of silver wire, which is now replaced by silk-worm gut. This, if perfectly aseptic,



prevents effectively the formation of pus, which previously was thought to be due to the puncture with the needle.

Hernia has been cited as the result of inefficient closure of the wound, and so some operators advocate as an ideal method closure of the wound layer by layer. This is at present a favourite topic in surgical societies. Personally I have met with but few cases of hernia after laparotomy, but they are more frequent after Caesarean section, and result not from the method of closing the wound, but from the spinal curvature, which throws the entire weight of the intestines upon the abdominal wall.

The idea of total extirpation of the uterus is about the latest development of abdominal section. It was previously condemned on account of the difficulties and dangers attending it, such as bleeding, wounding the ureters and sepsis from the vagina. Such objections persistently repeated were looked upon as insuperable, and, in fact, like the fear of wounding the peritoneum, for a time acted as a barrier to all progress.

The treatment of fibroids therefore was limited to medical means, such as iodides and mineral waters.

The disappearance of inflammatory growths which had been looked upon as fibroids also delayed any advance, and so the haemorrhage resulting from such growths continued to be treated by ergot and later by electricity.

Apostoli's method excited much interest, more especially as it was taken up by Sir Spencer Wells, and still more enthusiastically by Keith. Too much, however, was claimed for electrolysis, and very soon it was found that, although beneficial as a haemostatic and tonic, it failed to produce permanent diminution much less to dissolve the tumour.

The wonderful success following ovariectomy led Tait to remove the uterine appendages for the cure of haemorrhage from fibroids with good results, although some allege that such procedure is followed by grave mental disturbance. No doubt this idea arose from the fact that many ovaries were removed for so-called ovarian neuralgia in women, who from their mental condition were unfit subjects for operation.

Keith's greatest success lay in the extension of abdominal surgery to the removal of uterine myoma, an operation which



meant only the removal of the tumour, but which may now include the removal of the entire uterus, either for myoma, sarcoma, or cancer. The following cases are illustrative of the necessity and success of such a procedure.

*Case 25.* Mrs. C., aged 36, was admitted to the Western Infirmary, under my care on July 16th, 1895, complaining of great distension of the abdomen. The patient considered herself about five months pregnant, but as the abdomen was so much distended she consulted me regarding her condition. She stated that she had always enjoyed the best of health until the spring of the present year, that menstruation commenced at the age of 15 and continued perfectly normal and regular until February, 1895, that she had been married for about two years, and had had no children and no miscarriages.

About eight years ago the patient noticed for the first time, and quite by accident, a swelling in the left iliac region. It was about the size of a hen's egg when she first felt it. For a month or two it increased in size slightly, then ceased growing, and remained stationary until she became pregnant at the end of February. On February 19th she menstruated for the last time. Three or four weeks afterwards she began to be troubled with morning sickness, and about the middle of June she felt foetal movements for the first time. She was quite satisfied that she was pregnant: but what troubled her was the fact that her abdomen became so rapidly distended. It was, however, during the six or seven weeks previous to her admission into hospital that the distension seemed to increase most rapidly.

Her general condition on admission was not very satisfactory. There was great oedema of the legs and thighs, but apparently no ascites. There was some dyspnoea. The mucous membranes were of a good colour. She had no difficulty in passing urine, but her bowels had been very constipated. There was nothing abnormal in the lungs and heart; milk could be expressed from both breasts. The abdomen was much distended, presenting the appearance of a pregnancy at full time. It measured 37 inches at the level of the umbilicus. On palpating the abdominal tumours, a large smooth, round, hard swelling was found to occupy the left side.



It crossed the middle line, and was continuous with a swelling on the right side, from which it was separated however by a sulcus. This swelling on the right side was elastic in consistence, but two or three hard rounded nodules could be distinctly made out upon its anterior surface. The uterine *souffle* could be heard over it, but no foetal heart sounds could be recognized.

On vaginal examination, the whole cavity of the pelvis was filled up with a hard mass firmly impacted into it, and continuous with the tumour above. So completely did this tumour block up the pelvic cavity that the forefinger could with difficulty be passed up the vagina. The uterus appeared to be very much drawn up, as the examining finger could not reach the os externum.

On July 19th the patient was examined under chloroform, but nothing further was made out.

On July 22nd abdominal section was performed. On opening into the abdomen a large irregular tumour was met with, the left portion consisting of an interstitial myoma, the right of the distended uterus. In addition, implanted on the upper and posterior uterine walls, were several subserous myomata, varying in size from a walnut to an orange. Having made an incision through the anterior wall, a foetus of 5 months was removed. It was perfectly formed, and had evidently only quite recently died. The placenta was well developed, and was easily detached. An elastic ligature was passed round the uterus and tumours as close as possible to the cervix and secured, after which the uterus with the tumours were cut away. The uterine and ovarian arteries could now be more easily reached, and were ligatured. The ovaries and tubes were also removed. The tumour blocking up the pelvis was with some difficulty drawn up on account of impaction and adhesions. Having enucleated this mass of tumour nothing remained but the cervix, which was also separated from its connections. The peritoneum was stitched round and round with catgut sutures to the mucous membrane of the vagina. These sutures were then drawn down into the vaginal canal by means of a pair of long forceps passed up into the abdomen through the vagina. The abdominal wound was then closed



with silk-worm sutures; no drainage tube was used. The parts removed weighed 27 lbs.

The patient made a good recovery. She had a little sickness on the third and fourth days, when the temperature thrice registered  $100.2^{\circ}$  F. After that it never rose above  $100^{\circ}$ , and fell to normal after the ligatures were discharged from the vagina on the tenth to the twelfth days. She left the hospital in the seventh week after the operation perfectly well.

*Case 27.* Mrs. J., *aet.* 32, was admitted on May 1st, 1896, complaining of swelling in lower part of abdomen, and discharge from the vagina. The swelling was first seen several years ago, and the discharge has been present for eighteen months.

Menstruation began at twelve years and was regular and natural until September last. Since then the discharge has habitually persisted for a fortnight at each period. Patient states that within the past eighteen months the growth has been very rapid. No pain was experienced till six weeks ago, but since then the pain has been at times very severe.

Examination of the abdomen reveals a very large tumour filling the cavity. It is hard and resistant, but not tender to the touch.

Operation was deemed advisable. The tumour and entire uterus were removed. The patient made a good recovery, and was dismissed in six weeks.

*Case 30.* Mrs. M'K., *aet.* 40, was admitted on June 16th, complaining of swelling of the belly. The tumour was first noticed eight years ago, and has grown gradually since, being associated with pain from time to time. The uterus is dragged up, so that the top of the vagina can scarcely be reached.

The tumour, with the entire uterus, was removed. Numerous cystic developments were found in the growth, which was a myoma, weighing over ten pounds. Patient dismissed well.

*Case 7* was sent in as one of ovarian cyst, but it was thought that the swelling was in connection with the liver, and so it was sent to the medical wards. It was however returned, and so an exploratory incision was determined upon. The cyst was found to be due to enlargement of the gall bladder, which was distended till it formed a large swelling in the abdomen. This



was opened, and three gall stones removed, one of them being as large as a nutmeg. The patient made a complete recovery.

*Cases 31, 46, 47, and 49* are examples of pelvic haematocele, another condition which has come to be recognized as requiring surgical treatment. These in most cases become encysted through the resulting peritonitis. For a long time the pathology of these cases was a matter of speculation, and a very common idea was that of Bernutz, viz. menstrual regurgitation. I remember distinctly how I was warned against tying or dividing the Fallopian tubes in Caesarean section to prevent subsequent conception. Such an act, I was told, would most surely be followed by an escape of the blood from the tube and ruptured Graafian follicle. In every case, now numbering about fifty, the tubes were tied, and until now, a period extending over ten years, not a single case has resulted from this cause.

At present, from observation and early operation, we have established the fact that in those cases of intra-uterine haematocele not arising from some traumatic cause, the origin is most likely due to the rupture of an ectopic pregnancy. As to whether the effused blood will become encapsuled much will depend not only upon the quantity of blood effused, but upon the rapidity of its effusion, whether through a lacerated tube or through its pervious abdominal ostium. Many cases of tubal clot or mole have been recorded, and probably such are the cases which do well without operative interference.

The embryo appears in many cases to perish in the tube at an early stage, and the case resolves itself into haemato-salpinx, with or without effusion of blood into the peritoneal cavity, through the abdominal ostium of the tube.

*Case 24* was an irreducible retroversion of the gravid uterus. As this is the only instance I have ever met in which reduction was impossible, I consider it deserves special notice.

Mrs. M., aged 35, housewife, was admitted to Ward VII., Western Infirmary, under my care on December 12th, 1895, complaining of a painful swelling in the abdomen of about five weeks' duration. She had always enjoyed excellent health. She was married at the age of twenty-one (fourteen years ago), and has had four children born alive and at full time; the



labours were normal, and she made a good recovery after them all, and has never had a miscarriage. Menstruation has always been regular except during pregnancy and lactation; her last period, on August 4th, lasted three days. She considered herself pregnant: was perfectly well, not even suffering from the usual discomforts of the early months, until about five weeks ago, when, as she describes it, her "urine stopped." Simultaneously with this she observed that her whole abdomen was enlarged so that she could not put on her usual clothing. A doctor was called in, and attended her until her admission to hospital. Her medical attendant informed me that the swelling persisted, and she was able to pass her urine only in "drops." This retention of urine was accompanied by pain and a feeling of distension in the lower part of the abdomen, with vomiting and constipation.

On Tuesday, December 3rd (seventeenth week of pregnancy), the catheter was passed for the first time, and 80 ounces of urine were drawn off. After this the swelling of the abdomen was found to be much reduced in size. It increased on the following day, but was again lessened by the withdrawal of a large quantity of urine. Mixed with the urine on this occasion, however, and for the first time, was a large quantity of blood. Since then blood has been present in the urine almost constantly, and during the last two days in a very much larger quantity.

On Sunday last, December 8th (early eighteenth week), the patient was rather better, and was allowed to rise for a little. This improvement, however, continued only for a couple of days, for on the 11th, the day before admission to the hospital, she was seized suddenly with what she described at the time as "labour pains," accompanied by a haemorrhagic discharge from the vagina. Dr. Fenwick, Dr. Miller, and finally myself were summoned in consultation, and we agreed that immediate removal to hospital was most desirable.

The following is the note of her condition on admission to the Western Infirmary: Patient is very anaemic. On inspection the abdomen is seen to be distended by a swelling which occupies the hypogastric, iliac, umbilical, and lumbar regions, and reaches almost to the xiphoid cartilage. It is



of somewhat doughy consistency in parts and painful in the flanks and both iliac regions. Percussion gives a dull note over the front of the abdomen and towards the flanks, but at the extreme sides the note is clear. The tumour is movable from side to side to a slight extent. Fluctuation is not present in any part of the tumour. On examination *per vaginam* a bulky dense mass is found filling the pelvic cavity, and firmly fixed in the pouch of Douglas. The os uteri cannot be reached by the examining fingers except under chloroform, when it is found situated above the symphysis pubis. Its posterior lip appears continuous with the swelling described. Before the operation the bladder was several times irrigated, when numerous blood-clots, shreds of mucus and epithelium were washed out. On withdrawal of the catheter on one occasion a blood cast of the ureter, some fifteen inches long, and about the thickness of a quill, was expelled. On December 13th, that is, at the end of the eighteenth week of pregnancy, I performed abdominal section, as the patient's condition was becoming critical. The incision had to be extended above the umbilicus before the peritoneal cavity could be reached, owing to the distended condition of the bladder, and even then the uterus could not be reached.

In order to empty the bladder an opening was made upon its anterior wall, extraperitoneally, and a large quantity of blood-stained urine and clot was extracted. This organ contracted almost like a uterus, showing the walls greatly hypertrophied. The uterus and left Fallopian tube were now reached, but the right tube was imprisoned in the pelvic cavity, with the impacted uterus. My assistant, Dr. Munro Kerr, introduced his hand into the vagina, and made steady pressure upwards, whilst I disengaged the uterus at the brim by careful traction forwards from the sacrum with my fingers. This was only effected with great difficulty. The bladder incision was then sutured with fine silk, and the abdominal incision in the usual manner with silkworm sutures. A double-winged catheter was retained in the bladder.

The patient, I am glad to say, made an uninterrupted recovery. The temperature on only two occasions registered more than  $99.4^{\circ}$ —that is,  $100^{\circ}$  on December 30th, a week



after the operation, and  $100.4^{\circ}$  on the 31st. The pulse likewise, except during the first two days, continued normal. She complained of some pain in both iliac fossae for the first week; it was always relieved by  $\frac{1}{4}$  gr. morphine suppository. It was not continuous, and never suggested impending abortion. The condition of the urine improved rapidly after the operation, so much so that in two days blood could only be detected by test, and a week after not a trace of it was to be found. The uterus steadily increased in bulk until her dismissal. On January 2nd movements of the foetus were distinctly felt by the patient, and a week later the foetal heart sounds were clearly made out. The patient left the infirmary on January 18th, six weeks after the operation, in perfect health.

The history of this case clearly shows the necessity for careful examination, as the physician too frequently attributes all the suffering to the fact of pregnancy existing. Frequently the retention of urine calls for relief, and then the displacement may be detected. Denman blamed a distended bladder for retroversion; perhaps he would have been nearer the truth had he put the retention of urine down as resulting from displacement. Independently of pregnancy, retroversion and retroflexion are very common, especially in women who have borne children. Should pregnancy supervene, the uterus may continue to develop until it becomes locked in the true pelvis. Again, the retroversion may result from some adhesions behind preventing the ascent of the fundus, or even suddenly from some exertion or fall whilst the bladder is distended.

Upon May 18th I received the following message from her doctor: "On Sunday, 17th, Mrs. M., of the retroverted uterus, of a large healthy male child. Abdominal wall lovely. Forceps at the brim. A stiff pull."

TABLE OF CASES.

	Name.	Age.	Married or Single.	Disease.	Operation.	Result.
1	E. E.	30	s.	Myoma of uterus, -	Myomectomy, -	Died.
2	M'L.	34	m.	Fibro-cystic tumour, -	Abdominal Section, -	Cured.
3	L.	50	m.	Fibro-cystic tumour, -	Abdominal Section, -	Cured.
4	R.	36	m.	Cyst of ovary, -	Ovariectomy, -	Cured.
5	M'C.	30	s.	Myoma of uterus, -	Oophorectomy, -	Cured.
6	R.	38	m.	Cyst of ovary, -	Ovariectomy, -	Cured.
7	G.	53	m.	Distended gall bladder, -	Cholecystomy, -	Cured.
8	H.	33	s.	Myoma, -	Oophorectomy, -	Died.
9	C.	28	m.	Encysted ascites, -	Abdominal Section, -	Cured.
10	M'F.	21	m.	Ovarian cyst, -	Ovariectomy, -	Cured.
11	M'L.	33	m.	Ovarian cyst, -	Ovariectomy, -	Cured.
12	W.	31	m.	Ovarian cyst, -	Ovariectomy, -	Cured.
13	M.	23	m.	Encysted ascites, -	Abdominal Section, -	Cured.
14	D.	23	m.	Ovarian cysts, -	Ovariectomy, -	Cured.
15	C.	36	m.	Myoma with pregnancy, -	Panhysterectomy, -	Cured.
16	S.	35	m.	Myoma of uterus, -	Myomectomy, -	Cured.
17	A.	24	s.	Ovarian cyst, -	Ovariectomy, -	Cured.
18	M'L.	36	m.	Ovarian cysts, -	Ovariectomy, -	Cured.
19	B.	35	s.	Ovarian cysts, -	Ovariectomy, -	Cured.
20	M'I.	38	m.	Ovarian cyst, -	Laparotomy, -	Cured.
21	M.	35	m.	Incarcerated retroversion with pregnancy, -	Section. Uterus replaced,	Cured.
22	E.	30	m.	Ovarian cysts, -	Ovariectomy, -	Cured.
23	C.	35	s.	Ventral hernia, -	Abdominal Section, -	Cured.



TABLE OF CASES—Continued.

	Name.	Age.	Married or Single.	Disease.	Operation.	Result.
24	Y.	29	S.	Ovarian cyst, -	Ovariectomy, -	Cured.
25	D.	23	M.	Ovarian cyst, -	Ovariectomy, -	Cured.
26	J.	32	S.	Myoma of uterus, -	Panhysterectomy, -	Cured.
27	F.	42	M.	Ovarian cyst, -	Ovariectomy, -	Cured.
28	C.	29	M.	Haemato salpinx, -	Abdominal Section, -	Cured.
29	S.	70	M.	Ovarian cyst, -	Ovariectomy, -	Cured.
30	M.K.	40	M.	Myoma of uterus, -	Panhysterectomy, -	Cured.
31	S.	46	S.	Ovarian cyst, -	Ovariectomy, -	Cured.
32	L.	21	S.	Ovarian cyst, -	Ovariectomy, -	Cured.
33	F.	36	M.	Double dermoids, -	Abdominal Section, -	Cured.
34	N.	20	S.	Ovarian cyst, -	Ovariectomy, -	Cured.
35	O.H.	23	S.	Ventral hernia, -	Abdominal Section, -	Cured.
36	B.	40	M.	Ovarian cysts, -	Ovariectomy, -	Cured.
37	K.	24	S.	Ovarian cysts, -	Ovariectomy, -	Cured.
38	L.	27	S.	Ovarian cysts, -	Ovariectomy, -	Cured.
39	M.L.	27	M.	Encysted peritonitis, -	Abdominal Section, -	Cured.
40	F.	29	S.	Ovarian cyst, -	Ovariectomy, -	Cured.
41	C.	38	M.	Ovarian cyst, -	Ovariectomy, -	Cured.
42	B.	32	M.	Ectopic pregnancy, -	Abdominal Section, -	Cured.
43	W.	?	M.	Ovarian cyst, -	Ovariectomy, -	Cured.
44	M.G.	32	S.	Ovarian cyst, -	Ovariectomy, -	Cured.
45	F.	17	S.	Haematoma, -	Abdominal Section, -	Cured.
46	B.	34	M.	Ovarian cyst, -	Ovariectomy, -	Cured.
47	T.	27	M.	Ovarian cyst, -	Ovariectomy, -	Cured.





