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Published @ 2017 Trieste Publishing Pty Ltd

ISBN 9780649015634

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Edited by Trieste Publishing Pty Ltd.
Cover @ 2017

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BY

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[*REPRINTED FROM THE NEW YORK MEDICAL JOURNAL, APRIL*, 1874.]

NEW YORK:
D. APPLETON AND COMPANY,
549 & 551 BROADWAY.
1874.

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ON INTRA-UTERINE FIBROIDS.[1]

MR. PRESIDENT AND GENTLEMEN:

THE names of Atlee and Peaslee will always be associated as pioneers in establishing ovariotomy in this country as a legitimate operation. But the name of Atlee stands without a rival in connection with uterine fibroids. His operations were so heroic that no man has as yet dared to imitate him. A generation has passed since he gave to the world his valuable essay[2] on the surgical treatment of fibrous tumors of the uterus; but it is only within the last five or six years that the profession have come to appreciate the great truths which he labored to establish. Meadows, of London, and Thomas, of New York, have each achieved splendid results in this direction, and made valuable contributions to our literature. A few isolated cases of fibroid enucleation have been published

[1] Read at the annual meeting of the New York State Medical Society at Albany, February 6, 1874.

[2] Prize Essay: "The Surgical Treatment of certain Fibrous Tumors of the Uterus, heretofore considered beyond the Resources of Art." By Washington L. Atlee, M. D., of Philadelphia. Extracted from the transactions of the American Medical Association for the year 1853.

by others, and this is about all that we can boast of since Atlee first led the way for us.

Uterine fibroids are classified according to their relations with the tissues of the uterus. They are called subserous or extra-mural when on its outer surface; interstitial or intra-mural when embedded in and enveloped on all sides by the muscular structure of the uterus; and intra-uterine or sub-mucous when in the cavity of the uterus, with broad attachments to its walls. The first variety is, as a rule, not amenable to surgical treatment. The other two are. Histologically intra-uterine polypi and intra-uterine fibroids are identical, differing only in the manner of their attachment to the walls of the uterus. The polypus is pedunculated, while the fibroid, so called, is sessile; the former is attached to the fundus or to some portion of the inner surface of the uterus by a firm, fibrous band varying in size from half an inch to an inch or more in diameter, while the latter is extensively attached by fibrous and cellular tissue.

It is only within the last ten years that the removal of intra-uterine polypi has been rendered absolutely safe. By the old and clumsy method of ligation the mortality was immense. But by the modern method with the *écraseur*, and by the still easier method of excision with scissors, their removal is positively free from all danger. I have never seen a death, nor have I ever heard of one, from either direct or remote consequences of a properly-performed operation for polypus.

Intra-uterine fibroids are usually, I might say almost always, capsuled. They are sometimes polycystic; but more frequently solid. When cystic, the cysts vary in size from that of a filbert to that of an orange or a cocoa-nut. The solid tumors are generally more easily removed, because their tissue, being more resistant, does not break down so readily under forcible traction.

It is my intention here to speak of the improved methods of removing these tumors when practicable. I say practicable, because there are many cases, perhaps the majority, where operative measures are not called for, and would be unjustifiable. A fibroid is not, *per se*, a dangerous thing. It is rarely dangerous except when it gives rise to severe hæmorrhages, and then

only are we justified in attacking it by surgical means. If there is no unusual and exhausting loss of blood, it is wiser and safer for the patient to accept her condition as one of infirmity, and to make the best of it. Under these circumstances the tumor is simply a matter of inconvenience, producing temporary but bearable discomfort by mere mechanical pressure on the pelvic organs, and this generally only when the tumor is comparatively small. When it grows large enough to rise above the brim of the pelvis, the patient suffers only as she would with the gravid uterus at a similar state of development.

But, laying aside generalities, I shall proceed at once to illustrate the principles of treatment by detailing a few cases that have occurred in my practice (private and hospital) since our last meeting:

Case I.—Mrs. H., aged forty-six years; mother of four children all grown; has had menorrhagia for the last seven years. At first it was attended with great pain, but latterly the bleeding has been of a passive character, and painless. A few months before I saw her, she applied to a physician (female), who cauterized what was supposed to be granular erosion of the os. After a while, another physician was called in consultation, and the cauterizations were continued. By-and-by they discovered that it was not a simple case of granular erosion, but a tumor of some sort protruding from the canal of the cervix. The patient soon afterward fell under the care of Dr. E. H. Parker, of Poughkeepsie, who at once recognized the true character of the disease, and sent for me, saying we had to deal with an intra-uterine fibroid. I saw the case on the 6th of July, and agreed with him as to the necessity of surgical interference.

Mrs. H. was completely anæmic. When she was not losing blood, she had a profuse muco-albuminous leucorrhœa from the cavity of the uterus, which was quite as debilitating as the loss of blood. The os tincæ was found dilated to about an inch in diameter; the rounded, glistening surface of the tumor could be felt and seen on a level with the thinned edges of the os; the finger could be passed high up into the cavity of the uterus anteriorly and to the left side; everywhere else the

tumor was closely attached to the walls of the womb. Altogether the case was favorable for operation, and we thought it should be done at once. But Dr. Parker had two cases of erysipelas under his care at the time, and we feared to perform the operation at Poughkeepsie. As I was then at Newport for the summer, Dr. Parker sent his patient there for operation, and it was performed on the 26th of July. Dr. Sands, Dr. Engs, and Dr. Watson assisted, and Dr. Harry Sims gave nitrous-oxide gas. It took about two minutes to produce anæsthesia; the operation lasted seven minutes, and in one minute more there was entire consciousness; she was, then, just ten minutes under the influence of the gas. The tumor, about the size of the fist, was enucleated and removed with comparative ease. I did not allow any great loss of blood during the operation, for, as the attachments between the tumor and its capsule were broken loose, a sponge-probang was thrust up along the track of the enucleator to arrest the bleeding. When the tumor was removed, I passed several pledgets of iron-cotton into the cavity of the uterus. They were about the size of the first joint of the thumb, and each was tied with a strong thread to facilitate removal.

The day after the operation, the two lower pledgets were removed; on the second day two more; and on the third the remaining two. Vaginal carbolic washes were then freely used, and in a fortnight Mrs. H. returned home well, and soon regained all the freshness and vigor of robust health.

Case II.—Mme. de ——, of the city of Mexico, aged thirty-eight years; married at thirteen; gave birth to a child at eighteen; and had a miscarriage at twenty-four. Soon after this her health began to fail. She had nausea, and occasional vomiting; her abdomen began to enlarge, and she supposed herself pregnant again, notwithstanding the fact that she was regular. In about six months she had a violent hæmorrhage during one of her periods, and this occurred several times at intervals of five or six months. For the last four or five years the hæmorrhages have been severe and prolonged, often continuing from one menstrual epoch to the next. A year ago she consulted the eminent surgeon, Dr. Martinez del Rio, of the city of Mexico, who informed her that she had a large

intra-uterine fibroid, and he sent her to New York for operation. I saw her in June, 1873. She was anæmic, exhausted, and quite nervous from loss of blood. The os tincæ was dilated to about the size of a silver dollar, and the tumor could be seen and felt presenting at the os, but not projecting through it. The finger could be easily passed by the side of the tumor into the uterine cavity, where the tumor was felt to be firmly attached to the walls of the uterus in every direction, except anteriorly (Fig. 1). The sound could be passed into the cavity

FIG. 1.

between the anterior wall and tumor to the depth of five inches. The tumor was a pure myoma, and altogether favorable for operation—favorable: 1. Because the os was already dilated; 2. Because the tumor was firm and hard (non-cystic), and not liable to give way under strong traction; and, 3. Because it was probably not larger than a good-sized orange elongated by pressure. When Mme. de —— arrived in New York, we were passing through the epidemic of puerperal fever, which will long be remembered for its great mortality. Of course, I did not dare to perform such an operation in such an atmosphere, and she was sent to Newport to await my arrival