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Art. XII. Case of Excision of the Uterus. By Paul F. Eve, M.D., Prof. of Surgery, Medical College of Georgia. With remarks by C. D. Meigs, M.D., Prof. of Obstetrics and Diseases of Women and Children in Jefferson Medical College of Philadelphia.

To the Editor.

Dr. I. Hays — Dear Sir: When Professor Eve, of Augusta, Georgia, passed through Philadelphia, on his return from the meeting of the Association in Cincinnati, he gave me a pathological specimen, which is now in my museum. This specimen consists of the uterus of a woman of colour, which was removed by Professor Eve, in the hope that, by such a desperate operation, he might be able to rescue the patient from the imminent death which seemed by no other means to be avoided. The uterus, which he removed in the manner described in his letter, has been very much changed in its external form by the ravages of a cauliflower excrescence.

M. Colombat del'Isere informs us that the operation has been executed by Sauter, by Hoelscher, twice by Siebold, and thrice by Langenbeck; four times by Blundell; once by Bauner; once by M. Lizars; twice by Recamier; once by Dubled; twice by Roux, and once by M. Delpech; while this operation by Professor Eve adds one integer to the whole number, which amount to twenty operations, in all of which the result was contrary to the hopes of the surgeons.

M. Colombat expresses the opinion that operations for the removal of the womb in situ ought not to be in future performed, in consequence of the disastrous summing up of the statistical records. He does not apply his objections to the cases on incurable inversion of the organ.

There are too many examples of recovery after extirpation of the inverted organ to leave any doubt on the mind as to the hopeful-

ness of such an operation. Still, as I have firm confidence in the opinions I have published in other places as to the power of spontaneous cure of *inversio uteri*, I should hesitate long before resorting to the measure of extirpation. In my friend's operation, there is cause to congratulate him upon the skill and resolution manifested by him, and upon the hopeful success up to a certain point.

The following extract, from Prof. Eve's communications, will show that but for the recommencement of the original heterologue development in the vagina, the patient had, in the most remarkable manner, been rescued from death.

I send you herewith an extract of a letter from Prof. P. F. Eve; also a letter from Dr. J. A. Eve; and lastly, extracts from two letters from the surgeon.

Very respectfully, your obedient servant,

CH. D. MEIGS.

"On the 16th of April last, I removed the entire womb from a patient, who has recovered. The operation was performed at my surgical infirmary, in which I was assisted by my cousin Dr. J. A. Eve, Professor of Obstetrics and Diseases of Women and Infants, and by Drs. Murray, H. Campbell, Longstreet, and Montgomery, and in the presence of several others connected with the profession.

"The patient is a negro woman, twenty-eight years of age, has been married; but never conceived, as she believes. For more than three years, she has been labouring under uterine affection; at least, she has been annoyed for about that length of time by a vaginal discharge. The history of diseases among our negro population is generally very imperfect and unsatisfactory; and this is especially true as regards uterine derangements. All we can obtain in the present case, is that the patient had experienced great irregularity in menstruation, and had frequent hemorrhages from the vagina."

Yours, &c.,

P. F. EVE.

We now refer to Dr. J. A. Eve's statement of the case, as he observed it before she arrived at the infirmary in Augusta.

Augusta, April 24, 1850.

Dr. P. F. Eve:—

My Dear Doctor: Early on the morning of the 10th instant, I was called to visit Mary, the patient, whose womb you extirpated on the 16th, in consultation with Drs. Murray Cook, some eleven or twelve miles from town.

Under the influence of morphine, which had been given before my arrival, the patient had become easy. On examination, I found a tumour of considerable size in the hypogastrium, and the whole pelvis, to the outlet, filled and blocked up, with a lobulated, convoluted, incomprehensible mass, from which issued a copious and horribly fetid discharge.

As this was unquestionably carcinoma, cauliflower excrescence, encaphaloid tumour, or some malignant growth, the patient's certain doom was death, after a few months, or at most a year, of miserable existence worse than death, unless rescued by surgery, in the performance of a heroic operation which would involve the removal of a portion or the whole of the uterus.

If such an operation would ever be indicated or warranted, the age (28 years), the vigour of constitution and the comparatively unimpaired general health of the patient, made it proper in this case.

In consultation, I suggested to Drs. Murray and Cook that, as neither of us could take charge of, or do justice to, her case, so far from respective residences, she should be removed, as soon as practicable to your infirmary, where she would enjoy every advantage and benefit what favourable circumstances, as well as science and art, could afford her case; and that we should all meet and confer with you after her removal to this place; to which suggestion these gentlemen cordially acceded.

I know nothing of the previous history of this case except what has been related to us by Dr. Murray. In consultation, all the physicians present concurred in opinion with you, that the operation was one of extreme danger, and that the probabilities were as many, perhaps as a hundred to one against its success.

Before the operation, Dr. Murray and myself visited the patient, explained to her its great danger, and the very great probability that she might not survive it; telling her that, although it afforded but little hope, it was the only hope of delivery from suffering and death. We told her, further, that it rested entirely with herself to determine whether or not she would submit to the operation. With-

out persuasion or influence of any kind, she determined promptly and unhesitatingly to submit to the operation, terrific as it was represented to be. She is now doing well, and in all probability will return home next week. Your sincere friend,

J. A. EVE.

Operation—The bowels having been previously emptied, a large quantity of urine was drawn off by the catheter, which diminished considerably the hypogastric tumour, and proved the bladder to have been generally distended, as there was then no urgency to micturition—in fact, the patient was unconscious of the distension. About two pints were thus evacuated. Chloroform was now inhaled to its full anesthetic effects, when the vaginal tumour was seized by various forceps, but which, after large tubercular masses were torn off, was finally brought down to the os externum by the left hand. Finding it impossible to remove the firm resisting body now presented to view, it was carefully excised from above downwards, or in an antero-posterior direction, by the knife—I confess, with some suspicions at the time, it might be the uterus. One artery (now believed to be the left uterine), throwing out blood quite vigorously, was seized, and an animal ligature cast around it. A solution of sulphate of zinc was applied to restrain further hemorrhage, which has been considerable.

There was no protrusion of the bowels, nor was the case followed by any very severe symptoms. A most rigid confinement to the horizontal position was strictly enforced for about ten days, with absolute diet, &c. &c. The bladder, it is presumed, filling up again, pushed the intestines backwards, while the opening made into the peritoneum was closed by agglutination and subsequent adhesion. The rectum was evacuated on the fourth day after operation by warm water, and the bowels were moved freely by oil on the fifth.

In the mass removed, the uterus is readily recognized, with its Fallopian tubes, broad and round ligaments; but the os tincae is involved in the encephaloid degeneration. The tumour in the vagina was about the size of a child's head at full term. No one, it is believed, who has examined it has entertained the least doubt but that the entire womb was removed, and this includes besides the gentlemen who witnessed the operation, Dr. R. D. Mussey, Prof. of Surgery in the Medical College of Ohio, and Chairman of the Committee on Surgery for the past year in the American Medical

Association; and my preceptor, Dr. C. D. Meigs, the distinguished Prof. of Obstetrics, &c. &c., in the Jefferson Medical College, with whom the uterus has been deposited, and who has kindly insisted upon presenting the case to the profession in his own way.

During my absence at the meeting of the Medical Association in Cincinnati, the case was left under the care of my relative and assistant, Dr. A. P. Longstreet. The patient returned home on the 3rd of May, visited Augusta again on the 20th, to inquire why she had had no hemorrhages (menstruation) since the operation; and, in answer to a letter, Dr. Murray writes, on the 10th of June, that he saw her "up and about" the day before, and promised to bring her in a few days to my office.

Fifteenth of June, two months after the operation, the patient, Mary, has called, after riding eleven miles on a loaded lumber wagon. She is much improved in flesh and appearance, and has enjoyed good health. She says there has been a slight show of blood but once since the operation, and only a moderate discharge at times of colourless fluid. But I regret to add we have most unmistakable evidence, both ocular and by touch, of a rapid reproduction of the encephaloid disease, which in all probability must sooner or later destroy life.

(Extract of a letter dated Augusta, July 29, 1850).

My Dear Doctor: I write to say Mary, my non-uterine patient, is dead. She died on the 22nd of July, having lived three months and a week after the operation. She became oedematous (ascites, also), but had no hemorrhage, neither protrusion of the disease from the os externum. I regret no post-mortem was made by the physician in attendance, and I only learned her decease incidentally at the time,

PAUL F. EVE.

Dr. C. D. Meigs.

CRIPPLED CHILDREN'S SERVICES

Augusta Branch — DR. H. M. MICHEL, Clinical Orthopaedist

The Crippled Children's Services, administered by the State Department of Public Welfare through the Division of Institutions and Children's Services, in cooperation with the United States Children's Bureau, Department of Labor, is maintaining a programme for the care of crippled children in Georgia, designed to provide medical and nursing care and other services for crippled children whose families are unable to provide the necessary care through the usual channels of private medical practice.

This is a service programme exclusively. Funds are derived from State and Federal appropriations in approximately equal amounts. A "State Plan for Crippled Children" as required by the Federal Social Security Act is submitted by the State Department annually to the Chief of the Children's Bureau of the United States Department of Labor for approval. The plan states in detail the types of crippling conditions eligible for service as well as how, where, and by whom the services are rendered. The first State plan submitted by Georgia for Crippled Children's Services was for the last quarter of the fiscal year of 1938. This was approved by the Chief of the Children's Bureau, thereby enabling the service to begin as of April 1, 1938.

The Georgia law providing services for crippled children does not set forth the definition of a crippled child. It was, therefore, necessary that a definition be formulated by the State agency. This was done and the following definition accepted in the working plan for services for crippled children in the State of Georgia.

A child between the ages of birth and twenty-one years who is sufficiently handicapped by any orthopaedic condition as to restrict his or her normal development physically, socially or economically.

From the time of its inception in 1938, Dr. Henry M. Michel has been active in the Crippled Children's Services. A member of the original committee which set up this Division under the Department of Public Welfare, Dr. Michel has participated in its organization and has served as clinical orthopaedist since that time.

The Crippled Children's Division is divided into seven districts in the State of Georgia at this time. In each district center, clinics are held by the orthopaedist assisted by a district orthopaedic nurse. The Augusta branch includes twenty-four counties in the

eastern central portion of the State. This district has an area of approximately 10,239 square miles, a population of approximately 658,823, with an average percentage of 46% negroes and 52% whites. In the cities of Augusta and Savannah, manufacturing is the main industry, with farming and lumber in the rural areas. The outstanding health problems are venereal diseases, tuberculosis, malnutrition and hookworm.

Clinics for diagnosis and treatment are held on the first and third Mondays of each month in the Out Patient Department of the University Hospital, Augusta. Dr. Michel has carried the clinics in the Augusta District alone during the past calendar year since Dr. C. G. Henry left for service with the armed forces in the fall of 1942. He is assisted by Mrs. Clara Delleney, Orthopaedic Field Nurse whose office is on the ground floor of the University of Georgia College of Medicine.

STATISTICAL SUMMARY—AUGUSTA BRANCH

January 1, 1943 to January 1, 1944.

Total number of patients January 1, 1944.....	526
(Including new, pending and active cases).	
Total number of patients examined by Dr. Machel.....	551
Total number of hospitalization days.....	1624
(Including 790 convalescent days).	
Total number of casts applied.....	60
Total number of X-rays taken.....	37
Total amount spent for hospitalization and convalescent care	\$5,025.75
Total amount spent on appliances.....	\$1,453.77
(Braces, artificial limbs, special shoes, crutches).	
Visits to or in behalf of patients.....	367
(Six months period, August 1, 1943 to February 1, 1944).	
Number of visits to counties.....	22
(Visits to patients, conferences with official personnel regarding patients, during above period).	
Institutions visited.....	4
Georgia Academy for the Blind, Macon, Georgia.	
Georgia Warm Springs Foundation, Warm Springs, Georgia.	
Savannah Health Center, Savannah, Georgia.	
Georgia Training School for Mental Defectives.	

The Augusta District has been very fortunate indeed during the past year in having the faithful services of Miss Mary Ellen Wooten, Pastor's Assistant at First Baptist Church, who has ably assisted as a Lay Volunteer Clinic Aide. Recently, Mrs. H. Ray McLarty has volunteered her services as a Red Cross Nurses' Aid. We extend our deep appreciation to them as well as to the personnel in the Out Patient Department for their cooperation and assistance in the care of crippled children.

REBOUND PAIN AS A POINT IN THE DIFFERENTIAL DIAGNOSIS OF APPENDICITIS AND URETERAL COLIC

Report of a Case of Acute Appendicitis and Ureteral Colic
Occurring Simultaneously

By A. G. THURMOND, M. D., and J. Z. McDANIEL, M. D.

The frequency of appendicitis has led, in some quarters, to the idea that it is a simple, almost minor ailment. This is erroneous. While the clinical diagnosis may be made without difficulty when the symptoms follow the pattern outlined in the text books, it is sometimes difficult to make the diagnosis when they do not. One of the most complicating factors is disease of or about the right kidney and ureter.

The diagnosis of acute appendicitis like the time and tide waits for no one. Frequently the decision as to whether an emergency appendectomy shall or shall not be done must be made at an inopportune hour. But the decision, like that of the baseball umpire, must be made quickly and it must be accurate. Unnecessary appendectomies often lead to subsequent intestinal obstruction while delayed appendectomies lead too often to rupture and fatal peritonitis.

Rebound pain and tenderness over McBurney's point is one of the cardinal points in the physical diagnosis and is usually present except in abnormally placed appendices. Its absence does not exclude appendicitis entirely but greatly lessens its likelihood. Rebound pain and tenderness over McBurney's point is seldom, if ever present, when the symptoms are due to disease of the right kidney or ureter.

Microscopic examination of the urine should be carried out in every case. In the male the second glass of urine and in the female catheterized urine only should be examined. It should always be centrifuged. In small ureteral calculi the number of erythrocytes and leukocytes may be so small as to escape detection in the uncentrifuged urine.

We wish to report a case in which the symptoms were typical and confusing and in which the diagnosis of appendicitis was made and an operation decided upon solely on the presence of rebound pain and tenderness over McBurney's point. It was known at the time that there was both microscopic hematuria and pyuria and that there was very likely a small calculus in the lower third of the right ureter. This is the only case of ureteral colic and acute appendicitis occurring simultaneously that we have observed.

Report of Case

A white male, aged fifty years, arose on the morning of December 10, 1941, and prepared to go to work. At breakfast he was seized with a sudden, very severe pain, originating over the region of the right kidney and following the course of the ureter. This was partially relieved by repeated hot sitz baths and large doses of morphine and atropine administered hypodermically. Later in the day he became nauseated and vomited. Microscopic examination of the centrifuged urine revealed a few red and white blood cells. Gram stain of the sediment did not show any bacteria. A flat X-ray film of the kidneys, ureters and bladder showed a very small shadow in the region of the lower third of the right ureter which was suspected of being a small ureteral calculus. The following day his temperature rose to 99 degrees (F.) and the leukocyte count was reported at 16,000 with 88 per cent polymorphonuclear leukocytes. He exhibited marked rebound pain and tenderness over McBurney's point. Under cyclopropane anaesthesia an acute appendix was removed through a muscle splitting incision. The day following operation he passed a small calculus.

The pathological diagnosis was simple acute appendicitis. Chemical analysis of the calculus showed it to be composed mostly of calcium phosphate.

Convalescence was uneventful.

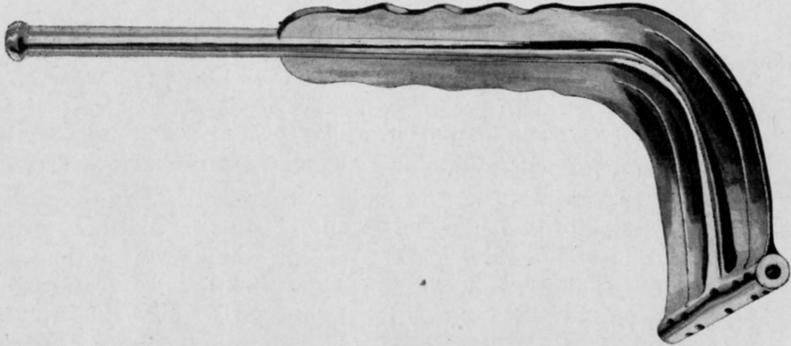
This case was of interest to us in that it was the first time we have seen acute appendicitis and ureteral colic occurring simultaneously and it demonstrates rebound pain as an aid in differentiating acute appendicitis from disease of the ureter and kidney.

CESAREAN SECTION:

IMPROVED MODEL OF COMBINED BLADDER RETRACTOR AND AMNIOTIC FLUID ASPIRATOR.

Five years ago there was described and illustrated, an instrument for retracting the bladder in low cervical or extraperitoneal Cesarean section, and at the same time for aspirating the blood

and amniotic fluid which escapes into the wound. Since then several improvements have been made. Not shown is a thumb vent on the convex of the tube to release suction when only retraction is necessary. The instrument is of value also in operations for ectopic pregnancy where there has been much intraabdominal bleeding.



1. Torpin, Richard: Cesarean Section : Instruments for Low Cervical Operation. *Am. J. Surg.* 37: 343, Aug. 1937.

Figure 1. Improved combination bladder retractor and amniotic fluid aspirator.

PROPOSED PLAN FOR LABOR AND DELIVERY ROOM SET-UP IN HOSPITALS

A survey of obstetric labor and delivery room layouts reveals that little intelligent effort has been expended to insure convenience and efficiency. No scientific standard has been set and in view of the enormous increase in hospital facilities about to be introduced throughout the world, attention should be directed to this subject. Much of the development of present day delivery rooms has been haphazard and too often represents so much wasted investment that changes are made with reluctance on the part of the hospital authorities. Furthermore the equipment is often unwieldy, inefficient and far too expensive for the results obtained.

In general the delivery department consists of three distinct but integral parts: (1) delivery rooms, (2) labor rooms and (3) the attending obstetrician's temporary quarters. A fourth may be added in the closely related nursery. The delivery rooms may be identical to the number of two or more, depending upon the number of patients cared for. Each should be at least 12 feet wide and 14 feet long with a wide entrance door at one end leading through an anteroom as illustrated, out into the labor room, or into a corridor connecting with it. The two anterooms should be altogether as wide as the labor room, 12 or more feet, by at least four feet. They then essentially add four or more feet to the length of the labor rooms, making them a total of 20 or more feet in depth.

The position of the chief equipment of the labor room, the delivery table, is illustrated. The only question is as to which direction the head of the table should point. For the convenience of the anesthetist the head should be nearer the anterooms. In this case, there should be a sink for the use of the obstetrician placed at the farther end of the room so that while washing his hands he may observe the progress of the dilation of the perineum and is able to scrub thoroughly if it is not too rapid. Furthermore, he can observe and direct the proper cleansing of the patient's perineum which is often neglected but should be thorough to prevent infection in the episiotomy wound. The assistant scrubs at the sink in the anteroom.

In regard to the delivery table itself, it is my opinion that it can be greatly simplified over the ones usually found in most of the hospitals, thereby allowing more to be spent upon other equipment which in certain instances, may be life saving. The table

could well be of white enamelled wood construction with sturdy legs and a wide flat top and drop leaf end. There is probably no good reason to have it adjustable for various elevations or for placing the patient in Trendelenburg or any other position. While it is conceivable that such might be handy in particular cases, I have never seen change of position to be necessary and I have yet to see one where it was used.

The chief accessory of the table is the leg holders. All of those seen so far have been studied carefully. Most of them are equipped with an entirely unnecessary appendage, the foot holder. If the obstetrician considers for a few minutes he will see that there is no need to support the feet. Such support is not used in perineal operations on gynecologic patients and they are fixed in position, as a rule, as long as the usual obstetric delivery. Consequently, an adequate popliteal trough firmly supporting and holding the flexed and abducted thigh with the knee flexed to a 100° angle is usually all of the fixation necessary. If the support of the thighs is rigid enough, even shoulder supports are not necessary. The nearest approach to adequate holders seen is that of the Gilbert Specialty Company, but these are still too light in construction and do not extend up on the thigh far enough, and the straps are too narrow and the buckles too frail. The object is to fix the patient so that her pelvis is at the edge of the table, to prevent displacement at the time of delivery or of repair of the perineum which interferes with maintenance of a sterile field. Too much mobility of the leg holders only adds to the too often complex mechanism and is not at all necessary. In fact one on the opposite side of the table from the patient's bed may be rigidly fixed. The one nearest her bed may be attached in such a manner that it may be rotated forward and downward to the table top level so that the patient may easily be shifted from the bed to the table and back again after delivery.

A further accessory and of great convenience in transferring the often comatose patient from her labor bed to the delivery table or back is a two-inch iron pipe firmly fixed by one end to each lateral room wall several feet above the center of the table and upon this rod rides a pulley arrangement which is attached to a heavy surcingle-like girdle around the patient's back for lifting her from her bed and then over onto the table. After delivery the process is reversed and she is transferred from table to bed without awkward effort on the part of the attendants and without danger of injury to her.

Further desirable articles of equipment are:

(1) Anesthetic machine, including equipment for administering oxygen; and a blood pressure machine.

(2) Mechanical suction for cleansing the pharynx of both mother and newborn infant. In the case of the latter a large rubber ear and ulcer syringe sterilized is excellent. Extra ones should be in reserve because frequently one slips out of hand.

(3) An infant electric-lighted laryngoscope and an infant tracheal insufflator with pressure control to 20 cm. water pressure¹.

(4) A large mirror fixed so that the anesthetist may observe progress of labor at delivery of the fetus.

(5) An automatic uterine packer to combat severe post-partum hemorrhage².

(6) A Leff scope³ so that the anesthetist may constantly hear the fetal heart beat.

(7) Black-board for patient's name, sex of fetus, time of delivery of fetus and of placenta.

(8) Heated crib with foot elevated.

(9) Automatic alcohol dispenser.

(10) Supply cabinets.

(11) Instrument tables.

(12) Spot lights.

The reader may have wondered about the purpose of the anterooms. One of them should contain a sink at least 12 inches deep, 12 inches from front to back and 18 inches wide. The front and back walls should be clear plate glass, and behind the back wall a light is placed. To one side there should be a drain board at the back of which is a balance scale for weighing the placenta. On the drain board there may be a two-way centimeter scale for measuring the size of the placenta. Near the sink there should also be a metal graduate containing 8 liters of water to be used in distending the fetal sac placed in the sink full of water. In this fashion the placenta is localized and visualized to a most remarkable degree. Such a routine study would greatly contribute to the obstetrician's knowledge of the pregnant uterus and would help him appreciate such anomalies as marginate placenta, circumvallate placenta, bilobate placenta, and placenta praevia, as well as the various

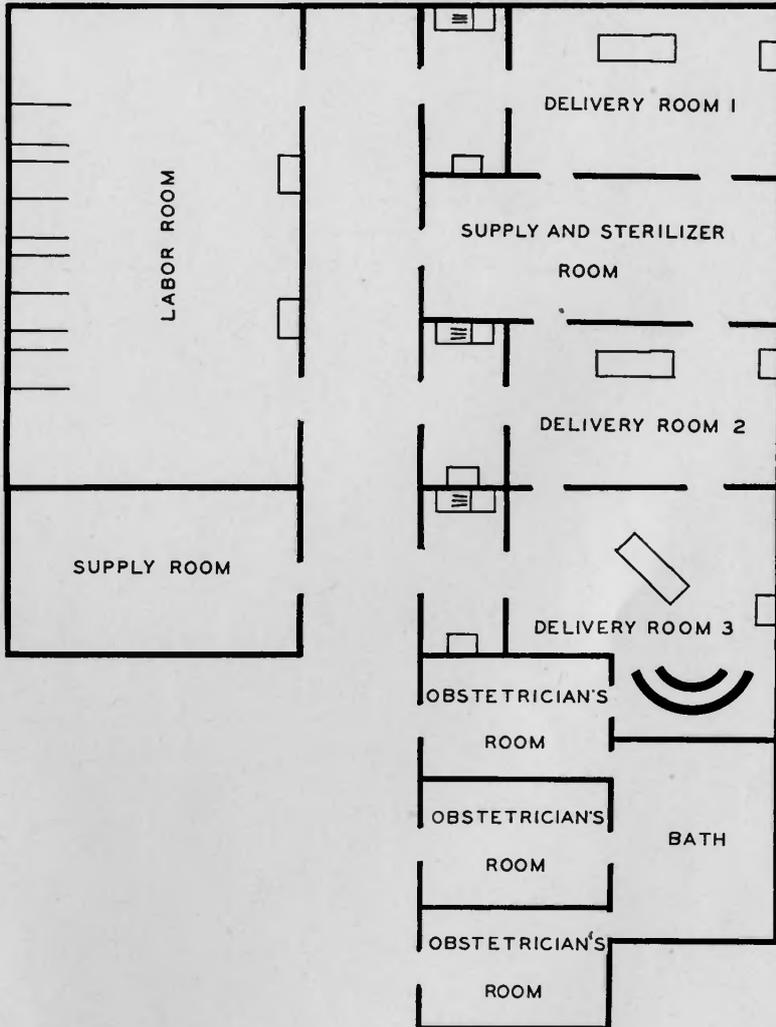
types of atypically shaped uteri. Besides, occasionally he might be able to contribute to the general knowledge by his observation of some rare and unknown abnormality. This anteroom also may serve as a scrub room for the assistant. The opposite anteroom should contain a table and light for the chart records.

The labor room should be 24 feet wide and the beds on large castors, occupying space side by side with the heads near one wall. Between each bed is a plywood partial partition, four feet high and extending toward the middle of the room for a distance of 5-6 feet. The partitions as illustrated are for the purpose of preventing the comatose patients before or after delivery from falling out of bed, thereby obviating the use of side boards. They could be upholstered in easily cleaned artificial leather so that the restless patient will not be injured by contact with them. The odd numbered partitions are double about 18 inches apart so that the attendant can perform minor cares without pulling the bed out. All other procedures may be done with the bed drawn out into the open part of the room. Proper ventilation and air condition throughout are essential. On the opposite wall are narrow desks for proper disposition of charts, rubber gloves, head stethoscopes, pelvimeters, etc.

The obstetrician's temporary quarters should be conveniently located. Each waiting obstetrician should have an individual room. The ideal service demanded is a check of each patient in labor by the obstetrician each 30 minutes. It is a relatively simple matter for him to sleep between times without worry if he knows he may be called on a moments notice. Each room should be equipped with a bed, radio and a small obstetrical library.

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Legend for Illustration: Drawn to scale, 1 ft. to $\frac{1}{2}$ cm. Showing main features, 4 foot high plywood stalls for the beds while patients are in labor, and anteroom arrangement for the study of the placenta and marking of records in the chart. Delivery Room 3 could be reserved for an intern or student teaching unit, being equipped with a small amphitheater.