CONTRA-INDICATIONS TO MINOR GYNÆCOLOGICAL OPERATIONS.

CLINICAL LECTURE DELIVERED AT THE NEW YORK POLYCLINIC.

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I WISH to direct your attention to-day to a subject which is of great practical importance to you, although I fear that you hear little said about it. I shall illustrate it by reference to two or three patients upon whom I operated several months ago, and who are not as much benefited as I expected they would be. It will be interesting to try to discover the reason in each instance. Unfortunately, by reason of your short stay here, and the fact that you see only occasional operations by individual surgeons, you are not in a position to follow the cases afterwards. You see an operation performed rapidly and smoothly by an experienced hand in a few minutes. With trained assistants and all the appliances of a well-appointed hospital there is no hitch, and the procedure seems to be simplicity itself. So it is when you know how to do it. The wound looks perfect, the dressing is applied in a scientific manner, and you are merely told a few days or weeks later that the result was good and that the patient was discharged "cured." Now, this is a very imperfect picture of the case, as you will find when you come to do the same operation in private practice. You have learned nothing about the precise indications for the operation, the long course of preparatory treatment which may have been necessary, and the condition of the patient six months or a year later. After all, the best test of the value of a minor gynæcological operation (I exclude cases of abdominal section) is not the appearance of the parts when the stitches are removed. The patient does not regard these matters from a purely æsthetic stand-point. She cannot share the surgeon's enthusiasm over

a "beautiful result" if several months elapse and she does not experience the promised relief. The perfect restoration of a torn cervix or perineum does not appeal to her as it does to the artistic eye of the operator or the spectator. She would never have consented to the operation unless she had confidently expected that certain definite symptoms which had become unbearable would be eliminated by it. These may have been one or many—pain, hemorrhage, sterility, or other troubles which prevented her from fulfilling the duties of a wife and mother. Now, when these symptoms remain unchanged after the operation there must be some reason for it. Either there is a failure from an anatomical stand-point, or the case was an improper one for operation. Failures of union are, or should be, rare with our present technique, hence we may regard the latter cause as the more common. I hold that it is quite as important for you as practising physicians to learn when *not* to operate as it is to become perfectly familiar with the details of gynæcological operations. Unless the patient is thoroughly prepared for the operation she will not be benefited by it. In a general way it may be said that surgical interference should be the last, not the first, step in your treatment. The patient will ask, "Shall I be entirely cured by the operation, so that I shall never need any more treatment?" Be exceedingly careful how you answer this question. The manner in which you do it stamps you as a conscientious or a careless gynæcologist. I do not see how any man can give a positive promise of cure in a case of pelvic trouble, since the condition is so complicated. How seldom do we meet with a laceration of the cervix without an accompanying laceration of the perineum, subinvolution, and endometritis! The symptoms which we attribute to the former lesion may in reality be due to one of the accompanying troubles, so that an operation would give little, if any, relief. The same result is seen after removal of diseased appendages when the uterus remains retroflexed and fixed by adhesions. In every case you must make up your mind which is the principal trouble—the one that gives rise to the symptoms from which the patient seeks relief. It may not be of pelvic origin at all. Be careful about confidently locating the seat of an obscure neurosis in a slight laceration of the cervix when it may be a fissure of the anus. I have a private patient now under observation who illustrates this last error perfectly. I have operated upon her twice, repairing a bilateral laceration of the cervix and an extensive injury to the pelvic floor, and finally tying off several hemorrhoids. When examined six months later the result was perfect from an anatomical stand-point, but clinically there was little, if any, relief from the backache and dragging sensations of

which she complained originally. Finally I have come to the conclusion that the pelvic symptoms are reflex, since I can find no cause for them in or around the uterus. The lady's bowels are obstinately constipated, and defecation is attended and followed for several hours with severe throbbing pains in the rectum, which are also transferred to the uterus and ovaries. She must have proctitis or ulcer, or an undiscovered anal fissure, and I propose to etherize her and ascertain. There is a peculiar spasm of the sphincter, which I have noted in other cases of this character. [The above opinion was justified a month later, when the patient was thoroughly examined under chloroform-anæsthesia. The rectum was normal, but the grasp of the sphincters, especially the internal, was so powerful that it was literally impossible to paralyze them without nicking some of the muscles. The ultimate effect of the operation entirely confirmed the diagnosis. The patient has now a regular daily evacuation of the bowels for the first time in several years, and there is considerable relief of the pelvic pains.]

With this brief introduction, let us look at the patients.

Case I.—This patient illustrates well what I have been saying. She was operated upon six months ago, lacerations of the cervix and perineum having been repaired in the usual manner; the flap-splitting method was adopted in the perineum. She was discharged at the end of a month with the parts in a perfectly satisfactory condition, and received the usual cautions against over-exertion and too early resumption of her matrimonial relations, which, as you will infer, are seldom heeded. Now, let us see how the operations have stood the test of time and the various vicissitudes incident to her condition. The perineum looks all right, but when I introduce my finger I find that it has little supporting power. This is my criticism of Tait's operation as compared with other methods of repairing the perineum—it is an easy and ingenious method, but the ultimate results are not all that could be desired. The cervix, as you see, is anatomically perfect; at the first glance you can hardly tell that it has ever been torn. The os is of normal size, the uterus is small and in good position. Why, then, does the patient return for treatment? She complains of a constant pain in the right side, the same that she had before the operation. On examination I find a prolapsed ovary, not much enlarged, but quite tender. Its presence vitiates the effect of both operations, so far as the relief of pain is concerned. It was of course recognized before the operation, but its importance as the cause of the symptoms was underrated.

Case II.—The operation in this case was a surgical failure, as you can readily see. The patient had a bilateral laceration of the cervix, with such extensive erosion and induration that I suspected commencing epithelioma, and accordingly I excised all the diseased tissue, removing a large wedge or core, so that I was obliged to insert a stem in order to maintain patency of the cervical canal. There was no sepsis or rise of temperature, but when I came to remove the sutures at the end of twelve or fourteen days the opposed surfaces simply fell apart, showing that there had been no attempt at union. A more careful inquiry into the patient's history developed the fact that a syphilitic taint existed. Under the usual specific treatment the wound began to granulate rapidly, and finally healed as you see it now, presenting a much better appearance than was hoped for at the outset. I have several times noted this same retardation of the healing process in syphilitics. The patient had an attack of pelvic inflammation after leaving the hospital, so that she is now much worse than before. I had intended to perform a second operation upon the cervix, but of course I cannot think of it now. I show the patient simply to emphasize the fact that before performing even a minor gynæcological operation one must be sure not to overlook any obstacle to success, whether it is a general or a local complication.

You have examined a young woman here who has a bilateral laceration of the cervix and needs an operation. There is no local contra-indication, and, after a superficial examination, I sent her to the hospital, expecting to operate at once. But a careful review of her history revealed the fact that she was an epileptic, evidences of cardiac trouble were discovered, and after keeping her under observation for a fortnight I decided that it would be unwise to subject her to the risk of anæsthesia, since the beneficial results of the operation would probably be either slight or *nil*. These are just the sort of cases in which a wise conservatism should temper our surgical enthusiasm. In private practice the proper appreciation of the contra-indications to an operation are even more important than technical skill. If you are convinced that it is not right to perform it, no mere pecuniary considerations should be allowed to influence you. If another surgeon differs from you and decides to operate, let him do it.

Case III.—Now, here is a patient upon whom I would not hesitate to operate at once. Why? She has a deep bilateral laceration of the cervix, which originally extended out into the vaginal fornix, resulting from the use of high forceps, "not wisely, but too well." The pelvic floor affords no support whatever, so that the heavy uterus sags downward until the cervix is almost at the vulva. The uterus is

movable and can readily be replaced; there is no tenderness in or around it, no prolapsed ovary. The patient is in fair general condition, with good muscular tone, and there is every reason to believe that the simultaneous repair of the cervix and pelvic floor (anterior and posterior colporrhaphy) would not only be successful anatomically, but would relieve the dragging sensations of which alone she complains.

Now, I have only time to make a few short deductions. How shall we decide in private practice when to advise an operation, and when shall we perform it? I do not think that it is always possible to arrive at a decision at the first interview. It requires only a superficial knowledge of gynæcology to recognize an extensive lesion of the cervix or perineum, a stenosis of the os externum, or a visible neoplasm, but the recognition of complications appreciable only to the practised touch is not so easy. It may be a great disappointment to the patient to tell her that she has some parametritis which must first be eliminated before it is safe to operate, and if you hint at a possible delay of weeks or months she may go to another gynæcologist, but you will have done your duty, even though from a selfish stand-point you may seem to be working against your own interests. I can assure you from bitter experience that it pays better to refuse to operate on a doubtful case than to yield to the solicitations of an impatient woman or to operate prematurely against your better judgment. If your patient is so fortunate as to escape a fresh attack of pelvic inflammation which may permanently cripple her, be sure that she will not have that benefit from the operation which she confidently expects, and which perhaps you were so unwise as to positively predict. Do not be guided by the wishes of the patient alone, nor by the opinions of others. If you are to bear the responsibility of an operation, make up your mind only after a careful review of the history of the case and a thorough examination, repeated if you have any doubt at the first. Analyze the symptoms, decide which are the most important, and seek to assign them to their true source, which may not be the prominent lesion that at once arrests your attention. Do not be on the constant lookout for reflex neuroses due to laceration of the cervix, for they are rare; if ovarian trouble is present the ovaries are far more likely to be the cause of such symptoms. Above all, be sure that if a laceration of the cervix or perineum is present it is sufficiently marked to require an operation. I cannot lay down any positive rules to determine this fact. It is largely a matter of conscience. If there be a subacute pelvic inflammation, prolapsed, tender ovaries, especially if they are adherent, or tubal disease, you will certainly not operate—at least with the expectation of curing the patient.

If the uterus is displaced and fixed by adhesions, you will certainly neither cure the displacement nor relieve the symptoms by restoring the cervix and perineum to a state of anatomical perfection. The operation will be an æsthetic procedure, nothing more. Finally, look well to the patient's general condition. If her entire nervous system is at fault, any operation may be more harmful than beneficial; or she may have some serious visceral affection, such as to render even a minor operation unwarrantable.

In conclusion, I would again remind you that the ultimate result of a minor gynæcological operation is of more practical interest both to the surgeon and to the patient than its skilful performance and a smooth, rapid convalescence.

AFTER-TREATMENT OF LAPAROTOMIES.

CLINICAL LECTURE DELIVERED AT THE BUFFALO GENERAL HOSPITAL.

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In our last two hundred cases of laparotomy the deaths have been six or eight, and, considering that many of the cases were desperate and that two or three died on the table, I think we have a right to say that the methods which we employ in this hospital are good. I think it quite important that you should know something about the after-treatment of cases of abdominal section. The first principle I lay down is to let the patients alone. Immediately after the operation the less interference, the less medication, the less food, the less drink, the less everything except quiet, the better. If I find a great deal of shock—there is always a certain amount—I use a little stimulant until reaction begins.

I have adopted the plan of using drainage but seldom. Some men use it in every case, others do not use it at all. I look upon a drainage-tube as a nuisance, and use it just as little as I can. I would rather delay the operation a little and put sponges into the peritoneal cavity than insert a drainage-tube and close the abdomen immediately. There is always a certain amount of fluid effused into the peritoneal cavity, bloody at first, serous afterwards. This effusion is to a certain extent a source of danger, because it is a pretty good culture-medium, and the temperature in the abdomen is right for the development of pathogenic bacteria. In order to stimulate the lymphatics to their greatest absorbing power, we keep the patient on a very scant regimen, giving only a teaspoonful of water now and then, so that the lymphatics will remove this fluid from the peritoneum. The patients say that the greatest suffering they have to endure is the lack of water. Within a short time, I presume, the peritoneal cavity becomes perfectly dry. Many authorities recommend if there be any rise of temperature, an indication of septic trouble, that a saline cathartic or saline enema be

given to move the bowels and still further stimulate the lymphatics by depriving the system of water. I have never used these saline enemata for this purpose, perhaps because I so seldom see septicæmia. The only cases we have seen here have been of such a nature that saline enemata would have done no good; for example, one case that resulted from the dropping back into the peritoneum of a stump[1] after hysterectomy.

When there have been numerous adhesions and much tearing of tissues and a greater probability of the effusion of fluid, the strict regimen with regard to water is all the more necessary.

As to the control of pain, I always encourage patients to get along without morphine if possible. One bad result of morphine is its effect on the intestines, stilling peristalsis, and making the intestines liable to form adhesions. I have lost two cases from obstruction of the bowels after laparotomy, and in each case adhesions to the stump after operation made a sharp angle in the intestine. I think that if no morphine had been given to those patients, particularly during the first twelve hours, till the intestines had had time to rearrange themselves after the operation, the obstruction of the bowels would have been less likely. I speak of rearrangement of the intestines, for during an operation they are often necessarily handled to a greater or less extent and their position disturbed. Again, the after-effect of morphine is to cause vomiting in a considerable number of cases. My first laparotomy case vomited almost incessantly for two or three days. This was one of my worst cases. When she was under the influence of morphine she did not vomit, but as soon as she came out of it she would begin again. Finally I stopped the morphine absolutely, and after vomiting for a few hours she ceased, and made a good recovery. Another bad effect of morphine is the increased pain in the intestines after stopping the drug. The intestines are paralyzed by the morphine, and when its effect begins to wear off the intestines begin to come out from the quieting effects in spots, so to speak, and there are irregular contractions, the nerves have not full control of the muscular coat, and from the irregular movements of the intestines colicky pains result. I have noticed that whenever I have taken morphine myself, as soon as the effect has begun to wear off I have experienced irregular griping pains in the bowels, and I have observed the same phenomenon in patients. I have therefore arrived at the theory which I have just given you. If the patient suffers very much from pain in the wound on account of

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[1] Due to bending of the pins.

coughing, muscular movement, and so forth, I strap the abdomen very tightly and encourage the patient to get along without the morphine as far as possible.

The movement of the bowels is another important thing. When I was a hospital interne I had nine laparotomies in my service, which was considered to be an immense number. The internes here have more than that in a month. We had no trained nurses in those days, and we had to do the nursing ourselves. It was the custom then to keep the patients under the influence of morphine; in fact, we began it two or three days before the operation, thinking that it would quiet the nervous system. The bowels were kept bound up for five or six days, with the idea that it would be dangerous to have them moved sooner. When the bowels did move there was a terrible time. Now I do not care if the patient's bowels move within an hour after the operation. In fact, I give the nurses a standing order to give an enema if there is colicky pain in the bowels. A large enema, however, should not be given, since too much water would be absorbed into the system. A small glycerin enema should be used instead. If the bowels do not move within a day or two, we give Noble's enema, thrown far up into the bowel, and it hardly ever fails. The formula is:

℞ Magnesii sulph., ℥ii;
Ol. terebinthinæ, ℥ss;
Glycerini, ℥i;
Aquæ, q. s. ad ℥iv.

Sometimes compound liquorice powder or other drugs are given by the mouth.

Food is given only on the second or third day, and in very small quantities at first. If there is any vomiting I prefer to let the stomach alone, giving only water or a little tea or coffee till the stomach is settled. We begin with light broths usually. If the patient can take milk,—and there is no use in trying to force every one to take milk,—we begin with that, two ounces being administered, hot or cold, according to the taste of the patient, every three hours. After five days the patients are allowed to take almost anything. Fruit, oranges, grapes eaten without the seeds, and particularly Malaga grapes, peaches, etc., seem to agree very well.

As regards the removal of the stitches, I leave the dressings on for about seven days. The parts are soaked in an antiseptic solution before removing the stitches, so as to avoid any infection due to drawing the sutures through the wound.

The patient is not allowed to sit up under fourteen days, on account of the danger of tearing open some of the deep tissues and ultimately producing ventral hernia. After this time the patients are allowed to sit up, and are sent home at the end of the third week, or a little later. After the wound is entirely healed, I like the patient to wear an abdominal supporter for two or three months. The London, the Gray and Foster, and the Marvin supporters are very good ones. We use one here devised by Dr. Howard A. Kelley, of Johns Hopkins University. This is inexpensive and answers the purpose well. It has a band coming between the thighs to keep the bandage from slipping up, and it is fitted to each patient. After the patient goes home, I advise her to keep very quiet for a number of months, and after three or four months she can do about as she pleases.

The temperature in these cases has a very constant normal curve. Immediately after the operation there is a fall, and in the evening there is a rise, and the second evening it usually reaches the highest point, 100° or 101°. Then it falls to between 98.5° and 99.5°, and remains there till about the tenth day, or sometimes sooner, when it drops to normal. You may always look for a rise on the first or second evening. This depends somewhat on the impressionability of the patient, on the amount of shock, etc. The pulse varies greatly in different individuals, ranging between 80 and 120 for the first few hours, and then it begins to come down. If I find the pulse-curve on the chart downward, I do not feel any anxiety about the temperature unless it goes unreasonably high. The pulse is a much safer indication of the condition of the patient than the temperature. I seldom give any antipyretics if the temperature does go up. If there is very severe headache and much febrile disturbance, an antipyretic may relieve the trouble, but I prefer not to mask the course of the fever, on account of its value as a diagnostic point with regard to septic infection.