THE RADICAL OPERATION FOR CANCER OF THE UTERUS[1]

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THE early recognition in recent years of cancer of the body of the uterus, and, as a consequence, the complete removal of the uterus, has led to such excellent temporary as well as permanent results that a consideration of this variety of cancer of the uterus is at this time entirely unnecessary. Some operators claim that nearly all of these patients are permanently cured of their cancer, and a most conservative estimate would be that fully two thirds of all cases of cancer of the body of the uterus operated upon never show any further manifestation of the disease. This fact is often lost sight of in the gloomy reports frequently published on the final results in cancer of the uterus. The diagnosis in the majority of the cases of cancer of the body of the uterus has been made from scrapings, and from them the diagnosis is rendered certain in the incipient stage of the disease. In no other branch of surgery has the value of the microscope as an aid to the surgeon been more signally demonstrated. In the present address, therefore, I shall limit myself to a consideration of cancer affecting the cervix.

CANCER OF THE CERVIX

Before considering the immediate and end results in the radical operation for cancer of the cervix, permit me to outline the salient points in our operative treatment of these cases.

Operability. It is very difficult to ascertain the percentage of cases that are suitable for operation. Many patients never see a physician until the disease is too far advanced for any radical operation, and often it happens that the surgeon is not even called upon to see the patient. Again, as pointed out very clearly by Taylor, numerous far advanced cases of cancer of the cervix are seen in the dispensaries, and only a minority of these reach the operating room.

When the cervix is freely movable, we consider the case operable; and although the growth may have extended to the vaginal wall, and even if the broad ligament on one side shows diminished mobility, provided the patient is in a fair physical condition, the abdominal operation is considered justifiable.

Before declining to operate, it is, as a rule, advisable to examine the patient under an anæsthetic, as one is occasionally able to detect that the lateral thickening is due, not to an extension of the cancer, but to a coincident inflammation of the tube and ovary. This we have noted on several occasions, and Taylor has recently drawn attention to this point.

TECHNIQUE OF THE OPERATION

I have never performed a vaginal hysterectomy for cancer of the cervix, but would not hesitate to do so were I dealing with a very stout patient suffering from a carcinoma of the cervix, associated with marked prolapsus.

Preparatory treatment of the cervix. In some of the cases, we have cauterized the cervix thoroughly and then abstained from all local treatment for a week, thus giving the raw area a chance to contract down. In some instances, this procedure has been followed by a marked "loosening up" of the cervix, and the uterus, which, prior to the cauterization had apparently been somewhat fixed, in the course of a few days had become freely movable. On the other hand, I have noted that some patients take a second anæsthetic within seven or eight days very badly; and so much have I been impressed with this fact that for several years I have, whenever possible, done the cauterization only just prior to opening the abdomen.

My colleagues at the Johns Hopkins Hospital, at the present time, after cauterizing the cervix and washing out the vagina, flush it out with an iodine and alcohol solution (iodine 3.5 per cent). When this is removed, the vagina is filled with alcohol. After this

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