**CIHM**
**Microfiche**
**Series**
**(Monographs)**

**ICMH**
**Collection de**
**microfiches**
**(monographies)**

**Canadian Institute for Historical Microreproductions / Institut canadien de microreproductions historiques**

© 1995

## Technical and Bibliographic Notes / Notes technique et bibliographiques

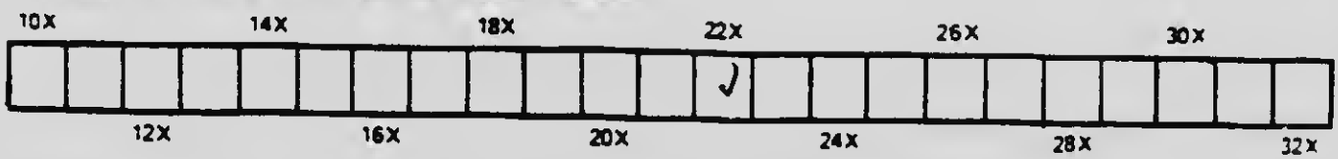
The Institute has attempted to obtain the best original copy available for filming. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of filming are checked below.

- [x] Coloured covers / Couverture de couleur
- [x] Covers damaged / Couverture endommagée
- [ ] Covers restored and/or laminated / Couverture restaurée et/ou pelliculée
- [ ] Cover title missing / Le titre de couverture manque
- [ ] Coloured maps / Cartes géographiques en couleur
- [ ] Coloured ink (i.e. other than blue or black) / Encre de couleur (i.e. autre que bleue ou noire)
- [ ] Coloured plates and/or illustrations / Planches et/ou illustrations en couleur
- [ ] Bound with other material / Relié avec d'autres documents
- [ ] Only edition available / Seule édition disponible
- [ ] Tight binding may cause shadows or distortion along interior margin / La reliure serrée peut causer de l'ombre ou de la distorsion le long de la marge intérieure.
- [ ] Blank leaves added during restorations may appear within the text. Whenever possible, these have been omitted from filming / Il se peut que certaines pages blanches ajoutées lors d'une restauration apparaissent dans le texte, mais, lorsque cela était possible, ces pages n'ont pas été filmées.
- [ ] Additional comments / Commentaires supplémentaires:

L'Institut a microfilmé le meilleur examplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modifications dans la méthode normale de filmage sont indiqués ci-dessous.

- [ ] Coloured pages / Pages de couleur
- [ ] Pages damaged / Pages endommagées
- [ ] Pages restored and/or laminated / Pages restaurées et/ou pelliculées
- [x] Pages discoloured, stained or foxed / Pages décolorées, tachetées ou piquées
- [ ] Pages detached / Pages détachées
- [x] Showthrough / Transparence
- [ ] Quality of print varies / Qualité inégale de l'impression
- [ ] Includes supplementary material / Comprend du matériel supplémentaire
- [ ] Pages wholly or partially obscured by errata slips, tissues, etc., have been refilmed to ensure the best possible image / Les pages totalement ou partiellement obscurcies par un feuillet d'errata, une pelure, etc., ont été filmées à nouveau de façon à obtenir la meilleure image possible.
- [ ] Opposing pages with varying colouration or discolourations are filmed twice to ensure the best possible image / Les pages s'opposant ayant des colorations variables ou des décolorations sont filmées deux fois afin d'obtenir le meilleur image possible.

**This item is filmed at the reduction ratio checked below/**
**Ce document est filmé au taux de réduction indiqué ci-dessous.**



The copy filmed here has been reproduced thanks to the generosity of:

National Library of Canada

The images appearing here are the best quality possible considering the condition and legibility of the original copy and in keeping with the filming contract specifications.

Original copies in printed paper covers are filmed beginning with the front cover and ending on the last page with a printed or illustrated impression, or the back cover when appropriate. All other original copies are filmed beginning on the first page with a printed or illustrated impression, and ending on the last page with a printed or illustrated impression.

The last recorded frame on each microfiche shall contain the symbol → (meaning "CONTINUED"), or the symbol ▽ (meaning "END"), whichever applies.

Maps, plates, charts, etc., may be filmed at different reduction ratios. Those too large to be entirely included in one exposure are filmed beginning in the upper left hand corner, left to right and top to bottom, as many frames as required. The following diagrams illustrate the method:

L'exemplaire filmé fut reproduit grâce à la générosité de:

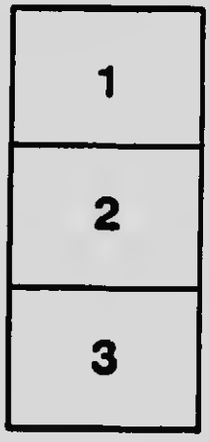
Bibliothèque nationale du Canada

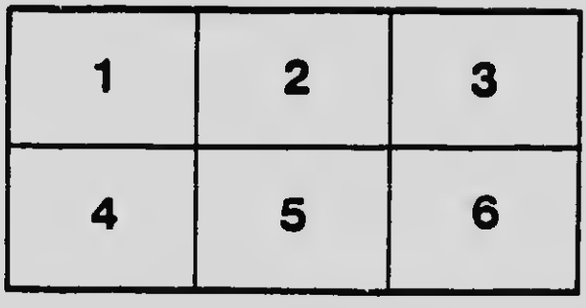
Les images suivantes ont été reproduites avec le plus grand soin, compte tenu de la condition et de la netteté de l'exemplaire filmé, et en conformité avec les conditions du contrat de filmage.

Les exemplaires originaux dont la couverture en papier est imprimée sont filmés en commençant par le premier plat et en terminant soit par la dernière page qui comporte une empreinte d'impression ou d'illustration, soit par le second plat, selon le cas. Tous les autres exemplaires originaux sont filmés en commençant par la première page qui comporte une empreinte d'impression ou d'illustration et en terminant par la dernière page qui comporte une telle empreinte.

Un des symboles suivants apparaîtra sur la dernière image de chaque microfiche, selon le cas: le symbole → signifie "A SUIVRE", le symbole ▽ signifie "FIN".

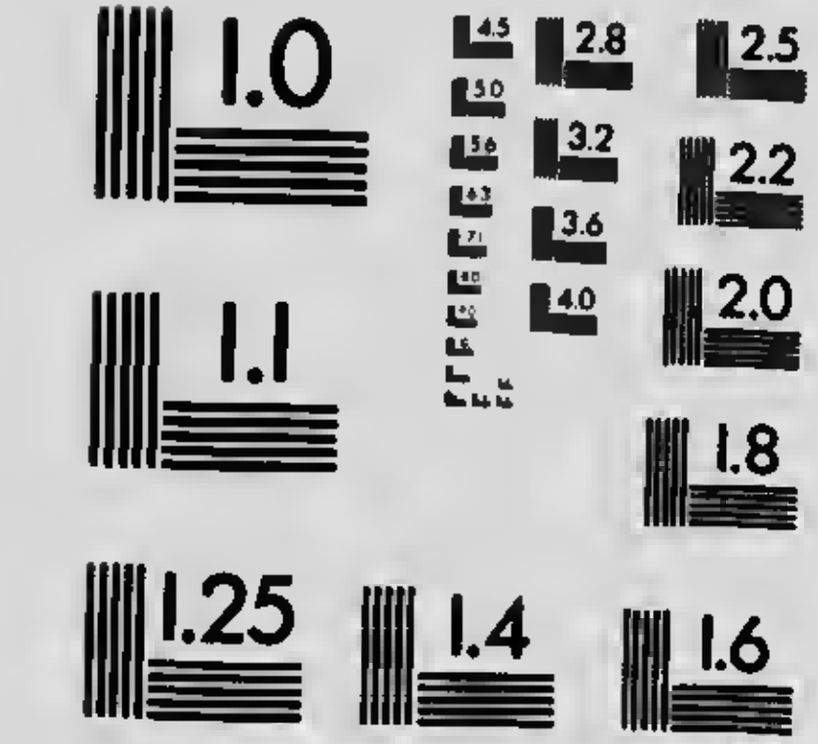
Les cartes, planches, tableaux, etc., peuvent être filmés à des taux de réduction différents. Lorsque le document est trop grand pour être reproduit en un seul cliché, il est filmé à partir de l'angle supérieur gauche, de gauche à droite, et de haut en bas, en prenant le nombre d'images nécessaire. Les diagrammes suivants illustrent la méthode.

MICROCOPY RESOLUTION TEST CHART

(ANSI and ISO TEST CHART No. 2)




APPLIED IMAGE Inc

1653 East Main Street
Rochester, New York 14609 USA
(716) 482 - 0300 - Phone
(716) 288 - 5989 - Fax

2

# AMONG THE TOMBS

BY

E. COYTEUX PRÉVOST, M. D.,
Gynæcologist to St. Luke's Hospital, Ottawa.

*Read before the Ottawa Medical Society, November 17th 1905.*

# AMONG THE TOMBS.

The object of all medical associations, apart from establishing agreeable and friendly relations, should consist if I am not mistaken, in the mutual communication of the interesting facts observed in the course of our practice, as well as the results of personal investigations, the reciprocal exchange of the various impressions received in our daily contact with those who suffer; in short, in contributing each in his own way to the intellectual recreation and the instruction of the others by fraternally sharing the fruit of our individual efforts to acquire knowledge.

This is precisely what brings me before you this evening; that is, the intention of raising a corner of the veil which covers my own experience, word which always admits of a good deal of sadness, because, if through experience we may perhaps boast of having obtained a little wisdom, still, it must be considered as a trophy generally composed of the weapons which have wounded us. After having listened to what I have to say to you, gentlemen, you will perhaps have added very little to what you already know concerning the diagnosis, the nature and the treatment of diseases, still, I have the presumption to believe that you shall not have entirely wasted your time, because the relation of my misfortunes which I intend to make will, I fancy, be profitable to all. To those whose conscience is afflicted with some regrets, it will bring the consoling conviction that they are not the only ones to mourn over their failures; to the more fortunate others who, free from remorse, have been so far spared by their destiny, it will impress their mind which the salutory warning that the Tarpean Rock is not very far away from the Capitol.

---

Read before the Ottawa Medico Chirurgical Society.

In receiving from our worthy President the amiable invitation to read a paper before this Society, the first thought that struck me was to report the brilliant cures which I have effected hy the skilful treatment exhibited in the course of my practice, the marvellons results attained by the means of my incomparable therapeutics, finally, to establish my indisputable superiority hy the display of dazzling statistics. But, such a subject would be most desperately common place; those things we read of everywhere in medical reviews when not in daily newspapers and, what profit would my hearers derive from the irksome enumeration of my personal achievements? I hold that you will find it far more interesting to rather hear of my disasters. One requires quite a large amount of courage, I know, to thus dare make a puhlic confession of his own sins, but, my friends, we are here all members of the same family, your discretion I trust as well as your indulgence. It is therefore without the least apprehension that I invite you to accompany me in the kingdom of the dead where, for ever, rest some of those who having chosen to confide their health and their existence into my hands, have nevertheless succumbed, victims of surgery or of the surgeon.

Undoubtedlv, we are right to feel proud of the immense progress realised in medical Sciences within the last twenty five years; the knife of the surgeon above all, every day saves the life of thousands of human beings already grazed by the wing of Death, and if the men of the middle of the last century were suddenly transported in our sumptuous amphitheatres. they would be amazed at the darings ventured upon by comtemporary surgery. But, these wonderful results which no one can gainsy, have not been obtained without difficulty, and this resplendent picture conceals a dark side where lie many a humiliating failure. That cannot be helped; it is always the eternal antithesis, which presides over the destiny of men and things in this world; it is by lightning that the atmosphere recovers its purity, misfortune and tears give back to the soul the serenity which it had lost, peace grows out of war, life originates in death. Our failures indeed are certainly to be deplored and leave in our memory painful remembrances which time does not always succeed to efface, but after all, it is the rest of humanity which

shall profit by the moral torments of the surgeon, rendered wiser and more prudent hy his trials and his experience. The revolution undergone by surgery in the last quarter of a century has rendered unavoidable the formidable necessity of mortality in major abdominal operations, but out of this relative evil, much good must proceed; in what conflagration to be extinguished does not fire unmercifully claim its share?

I will not dwell any longer upon these considerations, it would look as if I were begging for anticipated justification; let us enter without further delay into this cemetery where many a time I have alone carried my remorses and mv sighs.

---

Here, going in to the left, lies the body of a poor woman, 38 years of age, who died a few days after a simple myomectomy. Small fibroid, situated on the right side of the uterus; laparotomy, easy enucleation, closure of the abdomen. Then, septicemia and death on the 13th day.—Autopsy: The uterus is surrounded hy a collection of thick, pinkish pus; hardly any trace of peritoneal inflammation.

Why this fatal termination following such a simple operation?.... I have since, performed a great manv myomectomies, some of them on gravid uterus, and everything always passed off most naturally, without interruption of the pregnancy. Yes, hut at the time referred to, I was serving my first campaign in abdominal surgery; my operative work was done in a midst where all was almost exclusively left to myself. Alone at the head of a surgical service composed of inexperienced attendants, I was compelled to watch everything personally: assistance, ligatures, dressings; is there any wonder that some streptococci availed themselves of these conditions to stealthily invade the operative field to sow in it infection and death? According as the surrounding circumstances grew more favorable, that kind of accidents lost more and more of its frequency and to-day, a post-operative septic infection in my practice, private as well as hospitable, has become

quite an eventful incident which is met but at very long intervals. Still, whatever we may do and in spite of all our precautions, in my humble opinion we shall never be altogether sheltered from these formidable complications which in the majority of cases are chiefly responsible for the mortality following surgical interference within the abdominal cavity. A metaphysically aseptic operation is a myth, and the opening of the abdomen, whatever may be the conditions in which it occurs, must always be considered by the surgeon as a challenge which the organism is every time susceptible to answer by a disaster. How could it be otherwise? Putting aside technical faults or gross errors against the elementary rules of asepsis, in which case the surgeon receives then the well deserved chastisement incurred by his negligence and his incapacity, in the course of a laparotomy even most regularly conducted, there shall always exist some issues which will entirely escape our control and through which pathogenic germs may penetrate. We never close an abdomen without leaving behind in the peritoneal cavity, a more or less considerable number of micro-organisms which, if they happen to be placed in conditions suitable for their development, will prepare for us quite disagreeable surprises. It is a profound error to believe that the thousands precautions with which we endeavour to surround ourselves before and during operation, entirely protect us against the entrance of injurious germs. Apart from the fortuitous and always possible contamination of a piece of dressing, a ligature, an instrument, are we quite sure, for instance, that the hands of the operator and the assistants are thoroughly desinfected? You remember with this respect the experiments of Furbringer and others, and you know how difficult it is to obtain the absolute surgical purity of the hands of the surgeon and the abdominal skin of the patient. Again, the air of the operating room, is it always harmless? At the beginning of the antiseptic era, Lister never thought of operating but in a cloud of carbolic acid, in order to guard himself against the micro-organisms which are swarming in the atmosphere. He has since, it is true, and perhaps rightly so, abandoned that practice, still, let a sunbeam shine through an aperture in any room whatever, and you will easily verify that we literally breath, live, operate in a bath of dust each atom of which is the vehicle

of myriads of more or less morbid agents which will freely find access into the wide open abdomen of the patient. Even the mouth of the operator may sometimes become an important factor in the introduction of infectious germs into the abdominal cavity. You recollect the series of experiments undertaken by Hubner in Mikulick's Clinic? On a table which was supposed to be the operating table, four Petri boxes were arranged cross-like. The author, standing about twenty inches from the nearest box, spoke sometimes low and at other times in ordinary voice. These experiments have demonstrated that in every case and especially when one would speak loud, cultures would develop in Petri's boxes, and these cultures were particulary abundant in the boxes situated close to the mouth.

The above considerations prove that whatever may be the aseptic or antiseptic means to which we resort, germs will infallibly enter the open abdominal cavity and, if contamination produced by their presence is not in every case followed by untoward symptoms, it is because their nocent action is paralysed by the means of defense which the human organism possesses, provided the latter enjoys its normal integrity and that the number and virulence of the morbific agents are not excessive. Hence the imperious necessity of examining and securing the best possible bodily conditions of a patient who is going to be submitted to a major operation, in order that he might victoriously come out of the struggle he may have to undergo. Hence also the apprehensions always caused by an operation performed on a patient whose normal and physical conditions are more or less satisfactory, all other things being equal. Unfortunately, the appearance offered by certain subjects are at times very deceptive, and septic complications frequently kill patients presenting before operation a state of health apparently most favorable but in whose systemic machinery previously existed a lack of resistance impossible to suspect. It is in the same order of ideas that I venture to explain the traumatic fever which invariably follows all serious operations, without it being necessary to have recourse, as contended by several observers, to the hypothesis of the absorption of certain fibrogenous agents, etc., I rather believe that during the first days which follow the operation, the organism momentarily shocked by the

surgical traumatism, becomes a prey to germs introduced or even preexisting in the intimacy of the tissues and betrays its suffering by elevation of temperature ; but the struggle soon ends in its favour, the germs are disabled, fever disappears and physiological order is restored. In other terms, it is an autochton infection, a commencement of septicemia aborted by the powerful means of defense with which the human organism is endowed.

---

Brother surgeons, have you ever had the misfortune after an operation, to lose a patient from *secondary hemorrhage*? The two tombs which you see here, revive in my memory very mortifying souvenirs : I have frequently heard of operated patients having succumbed to hemorrhage caused by the slipping of a ligature ; the possibility of such an accident always made me smile. How could a blunder of that kind be committed? Surely, it is not to me that such a thing would ever happen! Presuming on my superiority, according to the definition of catechism, I was entertaining toward others a feeling of supreme contempt; experience was reserving to my unreasonable conceit quite a cruel punishment

During the month of February 1899, I operated a young woman, 30 years of age. Simply the bilateral removal of appendages. Ligature of the pedicle with catgut carefully applied. Shortly after awakening from anesthesia, the patient presented all the signs of internal hemorrhage : pale, bloodless face, thready, rapid pulse. Unfortunately, certain circumstances prevented my getting near the patient but several hours after the onset of these symptoms. She was immediately taken to the operating room where I rapidly reopened the abdomen which was found full of blood ; the ovarian arteries, both of them, widowed of their ligatures, were bleeding profusely. I tied them again and every thing in my power was done to revive the patient : intravenous injections of normal salt solution, ether and camphorated oil hypodermically, bandages around the limbs, but all of no avail, the patient died during the night.

Poor woman!. . . Still, the hæmostasis during the operation had been done with the greatest care I assure you. You will, I hope, grant me enough experience and intelligence to thoroughly know all the technical details in such matter; then, what guarantee have I against the possible recurrence of similar accidents in the future?

Last year, I anchored a right floating kidney on a woman aged 40; she rests in peace next to the one whose history I have just related. As this patient was in the mean time suffering from chronic pelvi-peritonitis, I opened the abdomen at the same sitting and separated numerous adhesions. After the operation every thing looked perfectly satisfactory, and with the exception of a few epigastric pains easily relieved hy a sinapism, the patient spent the whole afternoon in a comparatively good condition. About 8 o'clock the pulse suddenly became imperceptible, a sharp pain was felt in the inferior limb on the right side. Very soon, the face became bloodless, intense thirst, agitation accompanied by delirium. All our efforts to save the patient remained useless, she died at the end of the evening.

You may perhaps wonder why in this case I did not hasten to reopen the abdomen. Merely because I was not entirely convinced that there existed somewhere an internal hemorrhage. And, in the supposition that there was hemorrhage, was it situated in the renal region or in the abdomen? Besides I will confess, and this, without my being in a position to exactly define what I mean to say, the general appearance of the patient did not absolutely ressemble what we ordinarily observe on patients a prey to hemorrhage. Was it not rather operative shock? I hesitated. Caught in this alternative, you may easily conceive the puzzle of the surgeon. If the symptoms are attributed to hemorrhage whereas they are due to shock, the reopening of the ahdomen will surely be followed by fatal termination. If, on the other hand, in presence of hemorrhage which is mistaken for shock, we decide to resort to the heroic and so efficacious means of transfusion, we shall kill our bleeding patient whose arteries are wide open. Of course, the differential diagnosis of both these conditions is described and can be read in text-books, still, I assure you that in certain cases, the situation of the

surgeon is most perplexe and, to my mind, it is wiser under such circumstances to refrain from all active surgical interference ; painful as this abstention may be, it has at least the merit of sparing to the surgeon the regret of having directly contributed to the catastrophy.

---

Let us proceed along with our mournful promenade through the empire of the dead.

Here lie the victims of vaginal and abdominal hysterectomy ; eleven tombstones !

In order to learn the percentage of my mortality, you would like very much, I fancy, that I should state the total number of hysterectomies I have performed. I will take great care not to comply with your wishes ; the laws which have the honor to govern me grant all british subject the privilege of never incriminating himself. Besides, it will be far more interesting to you to open some of these tombs and become aware of the circumstances which closed for ever the eyes of the deceased which they contain.

! Do you see this hillock still preserving the withered vestiges of the flowers piously laid by the hand of a poor father ? It covers the body of a young girl, operated for a fibroid of the uterus. Subtotal abdominal hysterectomy ; operation rapid, regular, presenting no difficulty whatever ; previous health excellent ; death on the sixth day from septicæmia the cause of which has always remained entirely unknown to me. This is one of those cases with which everything made us expect an uneventful recovery and where fatality brutally came to crush our hopes. Poor child ! may the sod lie lightly over her !

Here is now an other victim of septic intoxication. This death is a striking example of the justness of the considerations above mentioned, with regard to the importance played by a previously good general condition on a patient who is to undergo a major operation. This woman, aged 42, came to the hospital, carrying in her abdomen a voluminous fibroma. Exhausted by successive hemorrhages, she was

deeply anæmic ; the face was pale, hæmatologic examination showed 2,000,000 erythrocytes and 25 % hæmoglobin. I refused to operate until the general state of health had become more satisfactory. After several weeks of tonic treatment, deeming circumstances favorable, in spite of still considerable anæmia, I performed abdominal hysterectomy. The next day, the pulse became rapid, miserable ; temperature gradually rose to reach 105 on the fourth day, and the patient died with all the symptoms of profound septic intoxication.— Moral—: On patients presenting such an anemic appearance as to almost make us feel tempted to look at it as being of a pernicious nature, whatever may be the benign character of the subjective symptoms, decline all major operation if you do not want to incur some unforeseen disaster.

---

Here I present you a group of three women operated for hysterectomy and who all three, chose the same door to depart from this vale of tears. All three equally made a good recovery from their operation and suddenly, without warning, they were carried away by an embolus. Here is their history in a few words :

Katie***, 49 years. Uterine fibroma. Abdominal hysterectomy ; operation easy. Normal convalescence. On the 9th day, about 3 p. m., she suddenly became ghastly pale and as if she was going to faint. Pulse was strong, regular, but respiration labored. She complained of sharp sub-sternal pain and hardly twenty minutes after the beginning of these symptoms, she had ceased to live.

Miss S.***, 40 years.— Hysterectomy for fibroid. No untoward symptoms until the 13th day when she was seized with violent cephalalgia. The next day, profound stupor, hemiplegia on the right side, conjugate deviation of the eyes, involuntary stools. For a couple of days, persistance of these symptoms which finally ended in death.

Mrs. W.***, aged 44.— Fibroma, abdominal hysterectomy. Very well untill the 26th day when symptoms of phlegmasia alba dolens

developed on the left side. This complication followed its ordinary course but, after a couple of weeks, gastric troubles supervened accompanied by urticaria. For several days she had obstinate vomiting which after having momentarily ceased, returned worse than ever, resisting all imaginable antiemetics. At last, washing of the stomach brought on considerable relief. One morning, while the gastric washing was being done as usual, the patient suddenly threw herself backwards and in a few seconds she was dead.

Is it really embolism which in this case was the cause of death? The preexisting phlebitis renders this supposition more than plausible. Still, could not the washing of the stomach be incriminated? By what mechanims? I do not know, but facts of that kind are reported by some writers; for instance, Roux affirms having several times seen patients suffering from ileus who died immediately after washing of the stomach, without any other apparent accident whatever.

It seems to me that I have more frequently than in my turn witnessed post-operative embolic complications. Thus again, I happened one day to remove a carcinoma of the breast on an old woman aged 68. She remained several weeks in my ward and was at last getting ready to go home when on awakening one morning, she was suddenly seized with suffocation, convulsive rigidity of the limbs and died almost at once when nothing towards the heart could make us suppose that death was of cardiac origin.

Embolism is the consequence of thrombosis as you all know. Thrombosis, followed or not by embolism, is more common than we think after surgical operations, especially those performed in the pelvic cavity. It is at times a mere aseptic phlebitis, evolving apyretically and due to an alteration whatever in the composition of the blood. The least fortuitous cause helping, intravascular coagulations become quite easy. The dilatation of the veins as for instance, in fibroid tumor of the uterus, the fraying of the blood-vessel walls during the manœuvres employed by the surgeon to enucleate the tumor, the ligature, the accidental pricking of vascular bunches by the needle, all these trau-

matic lesions are susceptible to act as provocating cause in the production of thrombosis. But, in the great majority of cases, it is the infection which is the most powerful factor of vascular coagulations. In spite of all precautions as I have already said, perfect asepsis is impossible ; a ligature may become infected, the infection may come from the neighborhood, from the intestine by example. Then, let a vein happen to be stretched, scratched, wounded, it becomes at once in a state of inferiority with regard to its resistance to the invading of pathogenic germs and the infection, although reduced to the minimum, may however end in the formation of thromhosis. If, by chance, a clot gets loose and is carried away by the circulatory stream, it will be stopped in some bifurcation of the pulmonary artery and cause death by embolus. But, in the absence of this complication, thrombosis can nevertheless exist and constitute a perpetual menace of this formidable accident.

Do we possess any means of detecting or suspecting these concealed thrombosis? Michel, chief of the surgical Clinic of the Faculty of Medecine of Nancy, points out as an important symptom, the gradually increasing frequency of the pulse during convalescence and this, while the temperature remains entirely or almost normal. Wyder shares this opinion and says that whenever we observe an increase of the pulse a few days after an operation, when the danger of infection is nearly over, without elevation of temperature, the patient feeling comparatively well, in short, without any appreciable cause, the attention of the surgeon should be attracted upon that symptom which may possibly be due to a manifest or latent thrombosis.

My personal experience in the matter differs from that of the authors I have cited, and in none of the four cases of embolus which I have met with, have I detected this peculiar character of the pulse. However, I wanted to bring to your knowledge the pretentions of these observers in order that, should you happen to notice the frequency of the pulse on patients placed in the conditions above mentioned, you might take the precautions which would to a certain extent release your responsability.

———

In this corner, always in the same enclosure, you see four tombstones, bearing a similar inscription— " Vaginal hysterectomy ". All four were operated for cancer of uterus. Three died from septicemia between the third and the sixth day. With the fourth, there happened an accident upon which I beg your permission to say a few words. The precervical tissues were infiltrated, indurated. Notwithstanding the care with which I proceeded to the separation of the cervix during the first time of the operation, I unfortunately wounded the bladder upon which I made such a rent that I was at once compelled to abandon the vaginal route, open the abdomen, and attempt to repair the wrong I had committed. All went well during the two days which followed the operation ; the vesical sutures held well as it was proven by the quantity of urine gathered through the permanent catheter I had left in. But, on the evening of the third day, the temperature went up, the pulse became rapid and the patient died with all the symptoms of intense septicemia. Well, at that time, there passed over all the wards of our hospital, a regular wave of infection caused by a case of puerperal septicemia coming from the Maternity and admitted in the hospital by mistake. Two other patients died of septicemia during the same week after insignificant operations, one after the mere amputation of the cervix and the other, three days following the ventro-fixation performed by my assistant. The latter, a few days later, carried the infection in his private practice, to one of his parturients who nearly died from it. Is it this accidental infection which caused the death of my patient or else, had she been contaminated during the necessarily long operation she had undergone in conditions of possibly defective asepsis ? I rely upon your indulgence to incline rather towards the first supposition.

At any rate, I avail myself of this occasion to declare that I have lost a great deal of my enthusiasm with regard to the ablation of the uterus by the vagina. Tax me if you like with ingratitude for thus forsaking my predilections of yore and burning to-day what I formerly adored, I none the less remain unshaken in the firm conviction that, in the majority of cases, when the uterus has to be removed, we can always do as rapidly and better in choosing the battlefield above the

Mons Veneris. My belief with that respect has been subjected to the same evolution as that of my excellent friend Professor Segond who after visiting the Americans in the hope of making them share his ideas concerning the superiority of vaginal hysterectomy, returned to France entirely converted to the american opinion. Since then, the partisans of the removal of the uterus by the vagina have all more or less withdrawn the arguments they use to oppose to those who preferred the abdominal route, such as : less mortality following vaginal hysterectomy, advantage of not opening the abdomen and, above all, the absence of all disgraceful cicatrix on the abdominal wall, convinced at last of the emptiness of this latter objection, because after all, our fair patients shall surely never come to dress low enough to alarm their coquetry.

---

Let us stop a moment on the edge of this solitary grave, shyly dissemhled in the shade as if it feared to revive by its aspect the humiliation which must have experienced the wretch who dug it.

A few years ago, a young woman came to consult me about a fecal fistula situated in the middle of the ahdomen hetween the umbilicus and the pubes. She had been operated a few weeks previously hy a surgeon of this city, for some pelvic affection. The abdomen had been opened but the wound never healed and of late, fecal matter was prefusely escaping through the inferior angle ot the incision. Peculiar sensation which she was complaining of in the rectum, led me to direct my investigations toward that region. In introducing the finger in the anus, I felt a soft foreign body upon which I immediately made a few tractions. Like the juggler who pulls out of his mouth yards and yards of ribbon the presence of which was not suspected, I gradually extracted one inch, two inches, six inches, eight inches of a long, soft, flexible body, all covered with fecal matter. It was a gauze pad, forgotten in the abdomen by the surgeon who had performed the operation.— I operated the fistula which healed up rapidly, and I could not restrain a contemptuous shrug in thinking of the colleague who had rendered

himself guilty of such a blunder. Ah ! surely, it is not to me that similar adventure would ever happen !

I had entirely forgotten the fact that, one day, scandalised by the unskilfulness of those who failed to properly tie their ligatures, I had conceitedly indulged in reflexions of that kind. A short time later, I was removing, on a young woman, a large tumor of the uterus. On the evening of the same day, the chief nurse, with a scared look spread upon her face, aprized me that, out of the twelve pads used during the operation, only eleven could be found. The next morning, I cleverly made the patient to understand that it was necessary to anesthetize her again in order to remove certain ligatures. I reopened the abdomen and easily found the missing compress. Usually, when I close the abdomen after laparatomy, I carefully protect the intestinal coils with a compress the extremity of which hangs out of the inferior angle of the incision and rests upon the abdominal wall. Constantly having it before my eyes, I cannot miss taking it out before tying the last stitches. In this case, owing to the large size of the tumor, I had to make a very long incision, and during the application of the sutures, the whole of the comparatively short compress was laying in the abdominal cavity. I rapidly ran a continuous catgut on the edges of the peritoneum held up by my assistant, and through the most culpable inattention, we had both forgotten to withdraw the article which remained behind in the abdomen. The nurse herself was equally guilty ; she should have attracted our attention upon this accident, even if she had not heard resounding to her ears, the following question which I seldom fail to ask before closing the abdomen : " *Have you all your pads* ? "

However, the patient was none the worse for this adventure and came off with a supplementary and entirely unnecessary anesthesia. If I had only been cured of my akwardness as well as the patient of her tumor ! ... But not at all ; listen.

Two years ago, I was called to operate outside of Ottawa, a woman suffering from intestinal obstruction caused by bands of adhe-

sions due to tubercular peritonitis. In the country, away from our well equipped hospitals and helped by insufficient assistance, we are frequently compelled to do almost everything ourselves : hemostasis, handling of the ligatures, the pads, the sponges. You must confess that this means a good deal, too much perhaps for a single man, especially when this man is the surgeon with all his senses kept on the strain by the details of a difficult and delicate operation. A few days after the operation, the colleague who had called me in consultation informed me by telephone that the patient had some fever, that she felt quite severe pain in the right flank where he trought he could detect tenderness and a kind of elastic swelling.

—" It is most likely, said I, a purulent collection ; apply hot fomentations and incise when you perceive fluctuation." That is what he did and a large quantity of offensive pus escaped.

Singular abscess after all, thought I "in petto" ! Where could it come from ?..

Two weeks later, new message ; the abscess would not dry up, suppuration was still qui profuse.

I then made at a distance a wonderful diagnosis ! Pray, do, at least, grant me this merit. " There is certainly a foreign body at the bottom of that affair, a compress perhaps."

The patient was brought in to Ottawa. An incision was made over the lump, which could be distinctly felt in the right lower quadrant of the abdomen, and I pulled out a gauze pad, rolled up and squatted in the midst of a cavity filled with fetid pus and and situated in the region of the appendix. At the end of a week, patient went home entirely cured. As the greatest magnanimity has always been one of the most remarkable features of my character, to the utter amazement of the husband, I declined to claim any fee for this second and brillant operation.

That is all very well, but it was written that I could not be for ever so fortunately protected by my lucky star.

Woman, 40 years. Jaundice ; painfull, ill-defined tumor situated between epigastrium and the region of the gall-bladder ; probably a calculus in the common duct. The abdomen was opened and I found a cancerous growth of the head of the pancreas which naturally was left undisturbed As the gall-bladder was largely distended with bile and most likely infected, I did a cholocystotomy. Soon after the operation, the nurse announced that a compress was missing, adding that it had most likely been left in the abdomen of the patient. I refused to believe that statement and assured her that in looking well the lost article would be found somewhere. Two days later, the patient's condition became such as to decide me to reopen the abdomen. I seeked for a long time in vain for the wretched compress, naturally directing my investigations toward the superior part ol the abdominal cavity. At last, I plunged my hand in the pelvis and there, laying over the uterus, I discovered the delinquent already in a fair way to contract adhesions with the surrounding tissues. The patient died two days later ol septicæmia. It is she who reposes at the bottom of this grave which I often strew with my regrets and my repentance.

Dear friends, if I made before you the narrative of these varions mishaps, it is certainly not—you will easlly believe me—with the vue to derive any vanity from it. But according to Holy Scripture, "Omnis homo mendax", every man is liable to err and no one as far as I know, can boast of having always succeeded to escape this axiom which threatens all human beings ; therefore, it is not impossihle that some day it should be the turn of some among you to be placed in similar circumstances ; well, very often, it suffices to signal a danger to multiply the chances of avoiding it.

To forget a sponge, an instrument, a pad in the abdomen of a patient is an accident apparently so stupid that it seems inconceivable that it should occur in the practice of an ever so liitle attentive surgeon. Still, reports of facts of that klnd actually swarm in medical literature. Allow me to cite a few of them, intentionally chosen among those which tend to demonstrate the tolerance of the peritoneum in certain

cases, and the solicitude with which Nature sometimes protects the surgeon from the evil consequences of his misdeeds.

A surgeon of Syracuse is one day called to see in consultation a woman who, four months previously, had her uterus and appendages removed by an eminent gynecologist in one of the largest hospitals of New-York. Convalescence followed its natural course and the patient returned to her home, carrying as remembrance of her operation only an apparently insignificant fistula, situated on the median line of the abdomen. For quite a while, everything went on without the least cloud when, at the end of July, four months after the operation, the patient commenced to feel tired, complained of headache, chilliness and had slight elevation of temperature during the early evening hours. These symptoms gradually increased and soon became accompanied by paroxysms of pain in the abdomen, especially localised in the right iliac fossa where could be detected the presence of a tumor, soft, tender and the size of a man's fist. Alarmed by these strange phenomena, whose nature could not be easily determined, the ordinary physicians of the patient telegraphed to the New-York operator who unfortunately was abroad on his holidays. They forcibly had to wait. Local iodine applications were instituted, supplemented by tonics of all descriptions. Strange to say! all the symptoms gradually subsided and about the end of August, the condition of the patient was entirely satisfactory, with the exception of the fistula which obstinately persisted to discharge.

Three weeks later, new symptoms supervened such as: persistent vomiting, constant nausea, obstinate constipation, in short, all the signs of intestinal occlusion. The tumor on the right side had faded away, but there existed an other, offering very nearly the same charater as the first, and occupying the whole of the inferior part of the abdomen on the *left* side. An immediate surgical interference was deemed necessary and decided for the next morning but during the night, the patient passed by the rectum, a large gauze pad folded many times upon itself and surrounded by feces. This pad had remained six months in the abdominal cavity and given rise to the train of symptoms

and physical signs already related; at last, after having plowed its way through the intestine, it had been rejected outside by the intelligent efforts of Nature, helped by Providence who evidently was watching with the utmost solicitude over the destiny of this privileged patient.

Merstens of Dusseldorf reports the case of a young woman who, a short time after having been operated for suppurated appendages, showed symptoms of intestinal stenosis, associated with severe cramp—like pains in the umbilical region. Examination revealed on that level the presence of cylindrical tumor which could be moved in every direction with the greatest facility. A new laparatomy performed five months after the first, showed the tumor to be constituted by a segment of the small intestine, largely distended and of a doughy consistence. Above the tumor, the bowel seemed perfectly healthy but below it, the coils were gradually lost in a mass of adhesions situated in the right iliac fossa. While these adhesions were being separated, a transverse and almost complete tear of the intestine happened on a level with the superior limit of the tumor. It was then perceived that the latter was due to a large gauze compress, tightly imbedded in the lumen of the bowel and imhided with fecal matter. Extraction of the compress; resection of the whole segment of the intestine already gangrenous; circular end-to-end anastomosis; complete recovery. That compress, forgotten in the abdomen during the first operation, must have at first given rise to an encysted peritoneal abscess; the latter, having later burst through a coil of intestine, peristalsis had caused the compress to gradually and entirely make its way into the gut. Then the communication between the peritioneal abscess and the intestine having closed up, the foreign body found itselft included in the intestinal cavity where it produced the symptoms of obstruction which necessitated the second operation.

Chaput, at a meeting of the Société de Chirurgie, held on December 12th, 1900, relate the history of the wife of one of his colleagues who was suffering from a pyo-stercoral fistula. This patient had

already been subjected to three laparotomies ; two for extra-uterine pregnancy and a third for ventral hernia. It is after this last operation, which dated from *seven years*, that had taken place the pyo-stercoral fistula for which Chaput perfnrmed a fourth laparatnmy The opening nf the ahdomen revealed the presence of a voluminous tumor, constituted by an intestinal coil which at first sight seemed to he the seat nf a nenplasm. A longitunal incision allowed him to remove a gauze compress twenty inches square. The rent in the intestine was sutured and the patient made an uneventful recovery.

In 1902, Pilate and Michaux published two similar cases. In one, the compress spontaneouslv came out through the anus and, in the second case, Michaux was compelled to resect the intestine, owing to the alterations produced by the foreign body,

These cases, gentlemen, tend to clinically confirm the correctness nf the interesting experiments which allowed Jalaguier and Mauclaire to study the migration through the intestine of compresses left in the peritoneal cavity in lower animals.

At last, one of the French newspapers cited by the Revue Française de Médecine et de Chirurgie, recounts that laparotomy was recently performd twice on a woman, once by an American and once hy a German surgeon, but her sufferings being unabated, her abdomen was opened for the third time by a French surgeon who found that she was harboring a pair of eye-glasses. It is suggested that a contention may arise as to whether it was the American or the German that planted them !

---

Now, Gentlemen, let us take this by-walk to the right and respectfully incline in passing before the tomb of these two poor women, killed by the so-called radical cure for ventral hernia. Both succumbed to analogous complications : fistula of the small intestine. With the first, afflicted for eight years with an enormous hernia following laparotomy, I found the intestinal coils adherent and extremely fragile.

Notwithstanding the greatest care used to separate the adhesions, the bowel was torn in several places. Sutures were applied everywhere, but a few days after the operation fistulous tracts appeared, half digested matter incessantly escaped out of the small intestine and the patient died from exhaustion. The operation performed on the second woman was far from being so complicated, and I still wonder to-day what could have been the cause of the fistula, situated also on the small intestine, and which ended in the same disastrous manner.

---

But what is the meaning of this multitude of crosses ? These rows of coffins and tombstones ! Are we in the catacombs or in some Egyptian necropolis ? Or are we rather, already transported in the valley of Jehosaphat were we are promised that the Sovereign Judge shall come to unmask at last in appalling trumpet-tones human hypocrisy ?

No, it is the vault where lie in their everlasting rest, the unfortunate individuals who, afflicted with appendicitis or intestinal obstruction, and in spite or perhaps on account of surgical intervention, have passed away from the operating table to the grave. Thirteen intestinal obstructions ; ten appendicitis ; twenty victims !

I had taken the firm determination not to divulge my mortuary statistics ; however, I shall venture to do it, recommending myself to your clemency. Out of thousand operations, I had fifty-nine deaths ; let us say sixty in round figures ; besides, nothing assures me that some of the wounded have not, unknown to me, gone to die elsewere. Well, out of these sixty dead, thirteen succumbed to intestinal obstruction, that is, almost 22 o/o !.. And if now I dared place opposite this percentage, the total figure of all those I operated for this formidable disease, you would shudder at the insignificant number of those who escaped. I look upon acute intestinal obstruction, as the most terrific ailment that the surgeon has to deal with, and the results of surgical interference in cases of that kind constitute in the hands of all, a regular opprobrium for surgery. Why ?.. Because, whatever may

be the nature of the obstruction, the operation is nearly always done too late. It is really astonishing to witness in some occasions, the extent and the gravity of the ravages which have already taken place in the abdomen of patients who, before operation, presented only mild subjective symptoms ; and it has often been my experience to find the bowels perforated and a considerable amount of fecal matter effused in the peritoneal cavity, when nothing in the comparatively good appearance of the patient, could have made me even suspect the existence of such serious complications. And, if I were permitted to risk an advice, I would say : In all acute intestinal obstruction, never waste your time in the illusive hope of spontaneous amendment or in the attempt to arrive at some etiological diagnosis which you will far more surely reach, when the lesions are before your eyes ; open the abdomen without delay ; four days, three days after the onset of the symptoms, sheath your knife or else expect a failure.

Here, my friends, we are among old acquaintances ; this is the part of the vault, allotted to those who died after appendectomy. There are ten of them ; too many perhaps, but relatively few when we take into consideration the great number of appendicitis that I have operated within the last twelve years. Let me tell you, in a few words, the circumstances which preceded the death of these patients :

No. 1.—Young girl, 17 years ; operated out in the country, on the 6th day of the disease. Very deep infection ; temperature 104 ; peri-appendicial abcess. Appendix resected ; drainage ; death two days after operation.

No. 2 —Little girl, aged 9 years. Fulgurous onset. Operated on the second day ; diffuse peritonitis ; pus everywhere. Resection of gangrenous appendix ; drainage ; death at the end of four days.

No. 3.—Young man, 15 years of age. Was seen in consultation on the 4th day of the diasease when I strongly urged operation which was refused. After a few days of abatement, the symptoms returned and I was called to operate. I found the patient in full peritonitis.

Appendectomy. The abdominal cavity was filled with pus which could be seen oozing in every direction amongst the intestinal coils. Death within 24 hours.

No. 4.—Man, aged 24 ; brought in to the hospital on the second day of the disease which at once assumed the course of general peritonitis. The abdomen was enormously distended. The cecum was found perforated close to Gerlach's valve ; intestines glued with lymph, but no purulent collection. The perforation was closed with sero-serous sutures and I deemed more prudent not to seek for the appendix. Iodoform gauze inserted. Death in a few hours.

No. 5.—Man, aged 37. Refuses operation during the first days, claims it on the 14th day. Abscess occupying the whole iliac fossa. Pus evacuated, drainage ; appendix not removed. Gets worse and worse and dies in a few days of pyemia.

No. 6.—Man, 40 years. Same story ; refuses operation at the beginning, operated on the 10th day. Gangrenous appendix, abdomen full of pus. Dies twelve days after operation of pyemia, accompanied by the characteristic intermittent course of temperature.

No. 7.—Man, 37 years. Sudden onset with sharp pain at McBurney's point. A physician consulted, believes in mere indigestion and prescribes purgatives. Symptoms becoming worse, patient entered the hospital where he was operated on the 4th day. Appendix gangrenous and perforated ; no pus. Resection of the appendix, drainage. Death three days later from septic peritonitis.

No. 8.—Dentist, aged 29. Enters hospital four days after the beginning of the disease. Gangrenous appendix removed. Purulent collection in pelvis ; drainage. Death on the 3rd day from septicemia.

No. 9.—Man, 40 years of age. Enters hospital and is operated on the 3rd day. Gangrenous appendix ; no pus. Resection of appendix and abdomen closed without drainage. All goes well for several days but, very soon, the course of temperature causes me to suspect reten-

tion of pus somewhere. The wound is reopened and the examination of the abdominal cavity remained entirely negative. Symptoms steadily got worse ; every evening, temperature rose to 105, preceded by severe rigor. Hamatological examination : 16,000 leucocytes. Death on the 21st day. Autopsy : Nothing special was found in the iliac fossa, the prececal region being absolutely normal. After prolonged researches, a large metastatic abscess was discovered between the folds of the mesentery at the superior part of the abdominal cavity. The sac contained a large quantity of offensive greenish pus and appeared closed everywhere, offering no communication whatever with the region of the appendix.

No. 10 — I have kept for the last, Gentlemen, the history of this little child's tomb, still humid with the tears of the poor mother. I also myself tenderly loved this charming little man of twelve years of age, and it was with a real feeling of anguish that, called one day to attend him, I discovered that he was suffering from appendicitis. I hasten to declare, Gentlemen, that I have long ago embraced the opinion of those wo are utterly convinced that appendicitis must be considered as essentially belonging to the province of surgery, and that, therefore, in almost every case, we must resort to operation, provided we are called in at the very onset of the disease. I know perfectly well that a great number of appendicitis may and do spontaneously get well and with the help of medical treatment alone, but what signs will at the beginning make us recognize the cases which will follow this favorable course? The cases which will remain benign and those which will end in deadly peritonitis, very frequently assume a the onset exactly the same behaviour. Should you confine yourselves in a sort of armed expectation, imprudently awaiting what is called "timely interference," I pity you ; such an attitude prepares for you very lamentable disappointments. Still, the word alon of *operation* always resounds in a terrific manner to the ears of the patient and the persons around, and the surgeon is invariably flooded with torrents of thanks and expressions of gratitude, whenever he declares that operation is not

necessary. I was well aware of the feelings of terror with which my little patient as well as his parents were impressed with this regard ; the disease, besides, was presenting itself with mitigated symptoms : very little fever, moderate pains, satisfactory general condition, in short, I decided to risk expectation ; for once, I would surely not have occasion to repent. For a whole week, everything went on beautifully, and I was already congratulating myself for having had the opportunity of being agreable to the whole family, when on the evening of the eighth day, I was informed by telephone that temperature suddenly rose to 103 ; there was constant vomitting, and the little patient was a prey to the greatest distress. I rushed to his side and found myself in presence of general diffuse peritonitis ! The patient was immediately taken to the hospital and operated as soon as possible. The whole abdominal cavity was filled with fetid pus ; the appendix, neither gangrenous or perforated, was adherent to the side of the pelvis. Resection and drainage ; death in a few hours.

This bitter lesson, my friends, shall always remain deeply buried in my memory. Let the interventionists and the non-interventionists continue if they like to seek the solution of their eternal problem ; let them heap up on both sides the most ingenious arguments in support of their respective opinion ; as far as I am concerned, I am altogether out of the fight, and whenever I shall happen to meet with a case of appendicitis which has not yet reached the end of the third day, I will urge operation, whatever may be the firmness of my diagnosis, because even if the latter be still wavering, I shall have in operating at the stage, everything to gain and nothing to lose

Now, Gentlemen, what influence has the operation had on the fatal termination of the cases I have just related ? It is hard to say. However, I may be permitted to believe that those patients simply continued to die, in spite and not on account of the operation they had undergone, and in the supposition that the disease had been allowed to follow its spontaneous course, the final result would have been the same. Moreover, how many of these patients would perhaps be still alive, if

instead of resorting to surgical intervention only when the organism was saturated with septic products, the appendix had been removed from the appearance of the very first symptoms !

Where, may I ask you, do all these cases of appendicitis come from ? Is this desease merely what we formerly used to call : perityphlitis, inflammation of the bowels, peritonitis ? I do not think so. Be it as it may, their number is simply astonishing and seems to increase more and more every day. Since we cannot he held responsible for the plague which afflict humanity, I venture to express the hope that this desease is not, for a while at least, doomed to disappear ; it alone, almost suffices to maintain the living of the physician ! Who knows ? It is quite possible that, tought by experience, we shall one day enjoy the gratification of having succeeded in reducing to naught, in the surgical treatment of appendicitis, the mortality of our surgical statistics. Then will it be the golden age of abdominal surgery ! Unfortunately for the specialist, every physician, authorized or not, but protected by antisepsis if not by his surgical knowledge, will not resist the desire of wielding the knife and do also his little appendectomy, and we, poor gynecologists, victims of the unjust application of a sort of Munro's doctrine, and driven away from a portion of a territory which in my opinion we rightly claim as our own, we shall find ourselves shut up in our last entrenchments, having for sole consolation our disregarded experience. Luckily, there will always remain to quench our thirst, some women tired of their ovaries or yearning for the restitution of the virginal dimensions of their relaxed genitals.

Gentlemen, I will end here this mournful excursion which you had the kindness to join. It is with a true feeling of relief that I quit this sorrowful abode where are buried with my poor dead ones, the painful impressions I so frequently experienced, the anguish which tortured my soul when, listening to the voice of my conscience after the loss of a patient, I felt myself impelled to face the problem of my direct responsability in the occurrence of the disaster. In the hope of interesting you, I made a sincere confession of the misfortunes that befell

me, and, seeking in nowise whatever, to escape the punishment incurred by my culpahility, without uttering the least murmur nnr even claiming the benefit of extenuating circumstances, I personally condemn myself.... to be stoned. Still, repentent, humiliated, the instinct of conservation, and the hope of perhaps escaping the fate which threatens me, induce me to entrust my safety in the following humble prayer: Let the surgeon cast the first stone who does not carry around with him a little cemetery in some corner of his memory.

L. COYTEUX PRÉVOST,

*Gynecologist to St. Luke's Hospital, Ottawa.*

November 17th, 1905.