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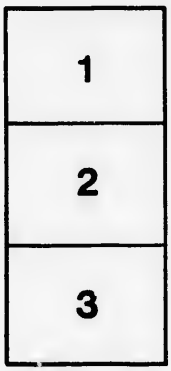

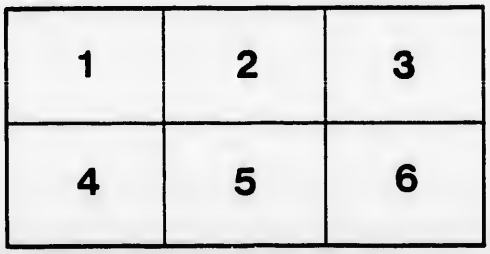

QUARTERLY RETROSPECT OF GYNÆCOLOGY

PREPARED BY

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Compress left in Abdominal Cavity and passed afterwards at Stool.—PILATE of Orleans (*Union Medical*, March, 1892) relates a case where a tarlatan sponge compress used in an abdominal section was left behind. On the evening of the operation there was vomiting and pain in the right iliac region. Phlebitis of the right leg set in. These symptoms soon disappeared and the patient made a complete recovery. Six months later pains in the region of the liver occurred; they became diffused over the abdomen, and vomiting and tympanites set in. At length there was a rise of temperature and a swelling in the pelvis was noticed. An operation was about to be performed when she passed the compress in a mass of hardened fæces. The patient recovered. Quenu relates a case where a compress was left in by accident. The patient died and the compress was found rolled up in a coil of intestine. Terrillow observed a case where pressure forceps remained eight months in the abdomen and came out close to the umbilicus.

Subperitoneal Hysterectomy.—Dr. Heywood Smith read a long paper before the British Gynæcological Society recently upon this subject. In summing up Dr. Smith concluded that the following lessons might be learned from the cases cited and discussion which would ensue.

(1) No two cases are alike. We cannot therefore lay down any hard-and-fast rule for the treatment of the stump; the fibroid invading the uterus in so many ways and situations, a certain choice must ever be left to the operator, but that we are to bear in mind that, where it is possible of application the sub-peritoneal method holds out as good a prospect of success as any other, and leaves the other pelvic organs free and unfettered by any constriction or adhesion.

(2) That Dr. Byford's method does not commend itself because of the length of time the operation takes, and it is open to the grave objection of manipulation being required both in the abdomen and vagina in the course of the same operation.

(3) That Dr. Skene's suggestion of dilating and inverting the cervical canal is very difficult practically, and has the same objection against it of associated vaginal and abdominal manipulation.

(4) The best methods, it appears to me, are those of Dr. Goffe and Mr. Milton and so far carried out in a modified way by myself.

The main points in the operation seem to be:—

(1) Make the peritoneal flaps sufficiently large, as they can be reduced, but not added to.

(2) Secure absolutely every bleeding branch of the uterine arteries, if possible, separately.

(3) Lace the whole pelvic peritoneal wound across with an uninterrupted suture of chromicised catgut, taking care that Lambert's stitches are used over the uterine stump, so that it is entirely sealed with peritoneal covering.

It is recommended that the cervical stump be divided as low down as possible, for the proportion of connective tissue to contractile tissue is greater than in the upper part of the uterus, where a contractile tissue prevails; there will therefore be less shrinking the more the amputation is carried through the cervix proper.

I would also point out the great advantage of using tincture of matico as a styptic where there is any oozing—it is very effectual and seems to do much less harm than others.

There remain three points for discussion:

(1) Shall we use a drainage tube? I think where there have been any adhesions and consequent oozing, a drainage tube should be used, for at all events forty-eight hours; but where, after the pelvic wound is laced across, the pelvis remains quite dry after sponging, there is no necessity for any drainage.

(2) Shall the cervical canal be destroyed by the actual cautery, or any other caustic? This is an important point and had better be discussed in connection with the question—

(3) Shall the cervix be transfixed and tied like the pedicle in ovariotomy, inside the peritoneal flaps?

Dr. Granville Bantock exhibited specimens of fibroid tumours of the uterus, illustrating the various methods of deal-

ing with these growths by abdominal section. The methods are as follows:—

(1) Enucleation of tumour and obliteration of bed of tumour by means of buried and other sutures. Appendages also removed.

(2) Application of *serre-nœud* to pedunculated fibroid, leaving uterine body, ovaries and tubes intact, and securing the pedicle in lower angle of wound.

(3) Application of *serre-nœud* around the uterus about level of internal os, and including both ovaries and tubes; amputation above or external to *serre-nœud*, and securing the stump in lower angle of wound (parietal).

(4) Application of elastic ligature, circular division of uterine envelope, partial enucleation of uterine body with its contained tumour or tumours, so as to lessen strain on broad ligaments, application of *serre-nœud* on peritoneal aspect, amputation of uterus, and securing stump in lower angle of wound. In this form, the appendages may be included in *serre nœud*, ligatured separately or even left intact, according to circumstances.

(5) Division of broad ligaments to allow tumour to be lifted out of the pelvis, elastic ligature, enucleation of tumour, application of *serre-nœud* so as to include the appendages, and securing the stump in lower angle of parietal wound.

(6) Elastic ligature, enucleation of tumour and uterine body, after circular division of uterine peritoneum, application of *serre-nœud* to uterine body thus enucleated, separate ligature, and removal of appendages, and securing the peritoneal envelope to parietes.

The first is an example of the intra-peritoneal method; the others are examples of the extra-peritoneal method.

Dr. Bantock recited the history of the cases from which the specimens were obtained.

Abdominal Section for Diagnostic purposes.—Dr. Clinton Cushing, of San Francisco, writes a short paper in defence of this subject. Dr. Cushing is unquestionably correct in his views and deductions, and it should be the duty of every surgeon to impress upon the physician the great necessity of having the abdominal cavity explored as soon as possible after being called to the case and he feels in doubt. Many lives will

certainly be saved, and the public will become impressed with the usefulness of it. To stand with folded hands for days or weeks, and speculate as to what might be the cause of suffering in a given patient, is certainly not scientific medicine of the present day, and will surely tend to bring upon our heads a feeling of disdain and want of confidence on the part of those to whom we should look for admiration and respect. I do not, however, agree with Dr. Cushing when he criticizes Mr. Greig Smith on the remark made in the latter's book, "No incision ought to be merely exploratory." "The exploratory incision of the skilled surgeon is widely different from that of the tyro." No man should make an exploratory incision unless he is prepared to complete an operation for removal of diseased parts found, provided, by doing so successfully, he ensures to the patient material benefit; therefore exploratory incisions should be made only by abdominal surgeons who have been careful to provide themselves against all emergencies, and thus increase to the highest possible degree the patient's chances for recovery.

Dr. Cushing mentions cases of ectopic pregnancy, of obstruction of the bowels, disease of the appendix, affections of the liver and gall bladder, of the kidneys and of pus collections in any part of the abdominal cavity, which surgeons equally skilled disagree upon in regard to a positive diagnosis without an exploratory incision.

Dr. Cushing describes minutely in his paper some interesting cases. One where he and other surgeons in consultation expected to find pus tubes, but instead found a distended gall bladder containing gall stones and pus. In another case cited he expected pus tubes again, but found as well an appendix abscess associated with a pyosalpinx of the right side.

In another case pelvic abscess was diagnosed which would have been treated, some years ago, by puncture through the vagina [or by some at the present day by electricity]. When the abdomen was opened a double pyosalpinx was found, and on further exploration a secondary foul smelling omental abscess with gangrenous walls was discovered.

In another case described the patient had experienced a miscarriage of six weeks pregnancy a few days previously. There was great distension of the abdomen, a large tumor felt in the pelvis and a temperature of 104.5°. An offensive uterine discharge, and the uterine cavity measured six inches. The

abdomen was immediately opened; a large sloughing uterine fibroid and general purulent peritonitis was found, pus was seen escaping into the cavity from the Fallopian tubes. The broad ligaments and the uterine arteries were tied off and the uterine tumour with appendages were removed and the stump closed by Schröeder's method with catgut sutures. The temperature at once dropped to 100° and patient eventually recovered.

Another case aged 20, temperature 102°, pulse 130, one child two years ago, had an attack of pelvic peritonitis eight months previously, since which time has been suffering great pelvic pain, progressive emaciation accompanied by fever and perspiration. Examination showed pelvic organs fixed and tender, abdomen not distended; when the abdomen was opened a great gush of fœtid pus, in quantity about three quarts, took place. This pus cavity extended from Douglas pouch to the ensiform cartilage. No pelvic or abdominal organs were in sight, being pushed away in every direction and buried in lymph. At time of writing this patient was convalescent, and her chances were favorable for recovery.

Dr. Cushing remarks that if tentative measures had been adopted here, the consequences would have been disastrous. There was no way of learning from external examination of the great extent of the disease, and the wonder was that she could have lived under such circumstances.

These cases of Dr. Cushing are of great value in point of instruction to the general practicing physician, upon whom so much responsibility in such cases rests. He should act promptly and give these poor patients a chance for their lives.

Dr. Fancourt Barnes reports in the *British Gynæcological Journal* for August, a case of ovariotomy in a patient 72 years of age. The patient on the third day developed a parotitis—non-suppurative—which subsided in a few days. This intercurrent condition was supposed to be due to injury to the pelvic organs and not to infection. Dr. Barnes drew attention to the fact that ovariotomy is not by any means common at that advanced age. Dr. Bland Sutton, in his recent work on "Surgical Diseases of the Ovaries and Fallopian Tubes," shows a list of 22 cases of ovariotomy in patients over 70 years of age.

Carcinoma of the Cervix in the Negress.—D. J. W. Williams, of the Johns Hopkins Hospital, reports a case of this kind,

probably the first one reported. The patient was a dark, full-blooded negress, 38 years of age, married for sixteen years; had eleven children, all labours being normal, and nursed all of her children. On examination, extensive infiltration was found involving the uterus and broad ligaments. The microscope confirmed the clinical diagnosis.

Dr. W. Chapman Grigg in his valedictory address as retiring President of the British Gynæcological Society, May, 1892, made the following remarks:—"I feel very strongly that if gynæcology is to accomplish all the good of which it is capable, the progress which is being effected must be brought home to the general practitioner, upon whom, in the majority of instances, falls the burden of the preliminary diagnosis, without which the resources of our art must to a large extent prove unavailing. We may fairly say that we have taken no mean part in breaking down many of the barriers which conservatism in science had raised to hinder the free evolution of our branch of medicine. Gynæcology, which not long since was practically *terra incognita* to the general practitioner, is fast becoming part and parcel of his education, and in proportion as this special knowledge becomes generalized, we find that the old idea as to the frequency of this or that disease requires to be modified." Dr. Grigg then refers more especially to the advance made in the surgical treatment of ectopic pregnancy, a condition which was regarded, until quite recently only as a pathological curiosity. In this and other morbid conditions he points out the great necessity for the family physician to be capable of making an early diagnosis, and to attain this end he should avail himself of every opportunity afforded in the examination of the female pelvic organs.

Extra Uterine Pregnancy.—Prof. Maur of Stockholm, reports two cases of interest (*Anals of Gyn. and Pæd., Sept.* 1892.) First case aged 29, last birth eight years ago. She became pregnant in February, 1890. In May she had a hœmorrhage which lasted for 14 days continuously. It then became intermittant.

June 6th.—She became seriously ill. Severe abdominal cramp and vomiting with symptoms of collapse. Abdomen distended; vaginal examination found cervix pushed to right, neither softened nor enlarged, the corpus over to left and

mobile. To right of uterus a round, slightly elastic resistance, the upper border of which reached about one inch above symphysis. It extended back to the spine. It surrounded the cervix and lay close to the uterus, though separated from it by a distinct furrow. It is smooth; it can be more plainly felt *per* rectum and gives to sense of touch the outlines of a tumor and not of an infiltration. It is very tender, traces of albumen in urine. Other organs healthy.

June 18.—Seized with severe pain in epigastrium and entire abdomen, vomiting, pulse feeble and rapid (112). Became pale with indication of profound collapse. Examination revealed little change in tumor.

June 21*st.*—*Operation.*—Large quantity of thin fluid black blood flowed through abdominal wound. Tumor composed of fœtus, and large mass of hard black coagulum occupied lower right pelvis, slightly adherent to surrounding parts. Fœtus lay outside sac in Douglas' pouch. Pedicle formed by right broad ligament. Secured by silk and tumour removed. On closing the wound a fresh hemorrhage was detected, and on search being made it was found to be due to the slipping of the ligature [showing the great uncertainty of silk in comparison with large-sized catgut]. The stump was seized with difficulty and religatured. Patient convalescent in fourteen days. The temporary albuminuria which existed before operation disappeared a few days after.

Conclusions.—June 7th—Hemorrhage into the sac, destroying life of fœtus (fourth month). June 18th—Rupture of sac and escape of fœtus, and intra-peritonal hemorrhage.

In the above interesting case Dr. Maur should undoubtedly have operated directly after the 7th without delay. His patient would have had a much better chance of recovery than by waiting until the sac ruptured and fresh and more serious hemorrhage had occurred. I would also suggest to Dr. Maur the adoption of large-sized catgut for heavy ligature; it is elastic and tightens with shrinking of the pedicle.

Case 2.—Aged 34: married fourteen years; nullipara. Became pregnant in April, 1890. June 1st, became suddenly very ill; severe abdominal pain, pale and collapsed, followed by unconsciousness for a long time. Severe vomiting all day. Following day uterine hemorrhage, which continued several days, with escape of blood-clots. During whole month of June

she suffered severe abdominal pain, and the abdomen became gradually enlarged. July 1st—Patient anæmic to extreme degree and appears to suffer intensely, especially with movements of body. Examination gave evidence of a tumour in the pelvis, divided by a central sulcus into two portions. Cervix looking forwards and fixed close to pubes.

Operation.—Intestines found adherent universally; a large black tumour found below intestines and adherent; tumour contained a large quantity of thin black fluid and hard masses of coagulated blood, also the fœtus. These were all removed and the cavity cleansed as well as could be done. It was then closed in the usual manner. Patient died on the sixth day. The pathologist, after an autopsy, gave it as his opinion that the patient died from septicæmia, which had existed prior to the date of the operation.

Conclusions were: Conception took place about April 1st. June 1st, rupture of fœtal sac occurred with escape of and considerable hemorrhage, after which it became encapsulated. At this time a general peritonitis developed.

[It is evident from the history of this very interesting case that June 1st or thereabouts would have been the time for her to have been admitted to hospital under Dr Salin's care, instead of which she was kept under medical supervision until the 27th, all of which valuable time was lost, and with it the life of the patient. Had she been seen on the 1st of June by Dr. Salin and operated upon she would in all probability have been saved.]

Sarcoma of Cervix.—Y. Pfannenstiel (*Virchow's Archiv.*, vol. cxxvii, part 2, 1892, p. 305) tabulates the twelve cases of this rare and very malignant disease which have been authentically recorded. The series includes a new case under his own observation. The patient was fifty-three. A structure taken for a simple mucous polypus of the cervix was removed. Eleven months later recurrence was discovered; a large racemose growth had developed. It was removed and the cervix scraped. Six months afterward a racemose mass filled the vagina. The patient was weak and cachectic. The uterus was extirpated. Symptoms of recurrence were detected five months later, yet sixteen months after the removal of the uterus the patient was alive, though very cachectic; the vaginal wall was infiltrated. This was her

condition when the report was published. With the exception of two patients lost sight of, the disease recurrred in all the twelve collected cases. Strange to say, though the clinical and naked eye characters of racemose sarcoma are fairly constant, their histology is more variable. They are pedunculated tumors, looking like a bunch of fruit, but they may be adenomata, myxomata, or even tumors consisting to a great extent of embryonic striped muscle cells (Pernice). Early diagnosis is very difficult. These tumors are much softer and more friable than true mucous polypi. Racemose sarcoma is much more malignant than any kind of cancer of the uterus or any other variety of sarcoma of that organ. The only active treatment justifiable in cases of this diseases is total extirpation of the uterus, and that severe proceeding is useless and not to be attempted if the incision in the vault of the vagina cannot be made over two-fifths of an inch outside the area invaded by the disease.

Intestinal Complications from Delayed Operation in Suppurative Disease of the Uterine Appendages.—Dr. CHARLES A. L. REED, in a paper read before the Academy of Medicine (*Cincinnati Lancet Clinic*, March 12, 1892), says: "I have from time to time presented to the academy specimens illustrative of complications arising from delayed operations in cases of suppurative diseases of the uterine appendages. For the most part the complications have consisted of pelvic adhesions which have rendered the enucleation of the appendages extremely difficult. In some cases a more serious accident occurs, and that accident consists in rupture of the pus pockets in an effort to lift out the appendages.

"In this way the pelvic cavity and the entire field of operation becomes contaminated. It is true that in a majority of such instances recovery takes place because thorough cleanliness is practiced by means of careful flushing, but it does not follow that it is a good thing to contaminate the field of operation with pus In the majority of all our fatal cases some such complication can be truthfully assigned as the cause of death, and such complications can, with equal truthfulness, be assigned to delay. When, therefore, the question of responsibility for the death comes under consideration, it must, clearly, and in all justice, be laid at the door of the person responsible for the delay."

He reports a case, still under treatment, though nearly well, of a woman of thirty-one years of age, who has suffered more or less for fourteen years from pain and tenderness in the region of the uterus. During this time she also had three pelvic abscesses, two of which discharged through the rectum and the third through the vagina. At the operation the appendages were most firmly bound down, and there was on the right side a cyst as large as a hen's egg. This mass was most firmly adherent to the jejunum, and in the attempt at enucleation a rent an inch and half long was made in the gut. This was closed by Czerny-Lembert suture and drained. Her condition remained good until the second day, when the belly became very tympanitic, and the pulse rose to 160. The patient had passed flatus, and was having no gastric disturbance. On removal of the drainage tube a large amount of odorless gas followed, the belly at once flattened out, and the pulse speedily became normal. Two days later more gas was permitted to escape by means of a grooved director pushed through the recently united incision, after which no more trouble ensued, and the patient is now well.

"There are several points in this case that are instructive. 1. The adhesion to the intestine shows the evil of delay. 2. The escape of gas into the peritoneal cavity shows the possibility of a pinhole fistula which will admit of the transmission of gas but not of fecal matter. 3 Gas from the intestine as high up as the jejunum is odorless and innocuous. 4. A drainage tube may become so fenced off that it will not drain the general peritoneal cavity even of gas."

In the discussion that followed the reading of the paper, the necessity of early operation in these cases was unanimously indorsed.

Sterility.—Dr. Arthur W. Edis says (*Med. Press*): It has been computed that in Great Britain alone there are five hundred thousand married females sterile, or an average of twelve per cent. of marriages which are unproductive. These figures convey, to those who have not studied the subject, a very inadequate idea of the amount of unhappiness caused in so many households by the inability of their occupants to fulfil the injunction given to our first parents to be fruitful and multiply. It has always been held as a reproach to a woman that she

has no offspring, and in many instances the desire for children is so overpowering that women will consent to risk their lives by submitting to an operation rather than remain sterile, or endure much pain and discomfort in the way of local treatment, if only a reasonable prospect of success can be held out to them. The question of sterility in the female has from time immemorial attracted the attention and taxed the ingenuity of the medical practitioner. The causes are so manifold, and the difficulties in arriving at a correct or rational explanation of the defect so great, that many practitioners give up the attempt to deal successfully with the subject in despair. Much as we may regret it, the fashion of the passing hour exercises a considerable influence on the successful treatment of sterility. By some, nothing but misplacements, versions, and flexions of the uterus are considered worthy of attention, and much ingenuity is expended in adapting various forms of pessaries to remedy these; others ignore entirely the position of the uterus, contending that this has little or nothing to do with the fact of impregnation, and direct their attention entirely to the condition of the uterus, believing that congestion and inflammation explain the whole difficulty. Undue acidity of the vaginal mucus or increased viscidity and alkalinity of the cervical mucus is looked upon by some as the all important cause, and efforts are directed solely to the rectification of this abnormality. Then again, stenosis of the os internum or externum is regarded as the all sufficient cause, and dilatation by means of graduated bougies, laminaria, or sponge tents, or rapid dilatation by uterine dilators resorted to. Division of the internal os by means of metrotomes or other cutting instruments finds favor with some, while others contend that complete division of the external os by Kuchenmeister's scissors, or other means, is the only proper expedient. Intrauterine stems are largely employed by others, and are credited with invariable success, though if all the cases treated by this method were published, the balance would probably be considerable against it, taking into account the risks and dangers attending their employment.

Surgical Treatment for Laceration of the Cervix.—Whenever a laceration occurring at the cervix extends through the internal and external muscular tissue, the mucous coat lining

the canal suffers materially from the violence. The plicæ palmatæ, which have been described under the term arbor vitæ, undergo serious disturbance in their relation to the other tissues with which they are connected. This condition often leads to congestion, thickening, and to induration of the parts involved, and to more or less hypertrophy and malnutrition of the higher uterine segments, and to changed relation and displacement of the lower cervical zone. When laceration occurs at the cervix, not only are the muscular and mucous structures injured, but the mucous glands that so freely abound in the cervical canal also become disturbed in their normal functional activity. It is especially in the cervix uteri about the arbor vitæ that the mucous follicles, which, when in a healthy condition, afford only moderate moisture for the maintenance of their function, pour forth an altered, perverted, or diseased secretion. The arteries and arterioles entering into these structures often become preternaturally developed or enlarged; there will often be found a greater interlacing or anastomosing of these vascular structures. This condition may lead to more or less local œdema, which the venules and lymphatics will fail to overcome. The structure of the uterine nerves, particularly those derived from the hypogastric and sacral plexuses, becomes so deeply involved that not only do the parts in immediate contact with the torn or injured surfaces become the source of much trouble, but all the tissues forming the uterine body may continue so heavily congested, and become so thickened, indurated, and globular, as to constitute that condition which has so aptly been termed subinvolution of the uterus. The treatment best adapted for the relief of the suffering that occurs in every such case, according to my experience, is that afforded by surgical measures.—*Dr. Clark* (*Med. News*).

Results of Vaginal Hysterectomy in Cases of Uterine Cancer.—Terrier and Hartmann (*Revue de Chirur.*, April, 1892) publish a series of eighteen cases of vaginal hysterectomy performed for the removal of cancer of the uterus, and also give the results of recent inquiries concerning eighteen other cases of a like kind, which were tabulated and published in 1888. In each series the immediate mortality from the operation was 23.5 per cent. In the second and later series

death was due in one case to shock, and in two cases to peritonitis. In one case the patient died on the fourteenth day in consequence of phlebitis of the main venous trunk of the lower limb. Of the patients referred to in the first series of cases who recovered from the direct effects of hysterectomy, two were living and in good health after long intervals—one after six years and four months, the other after five years and four months from the date of operation. In eight cases included in the earlier list recurrence occurred after intervals varying from six weeks to two years. In five of the second series of cases the patients when last seen were living after intervals varying from three years and five months to eight months. Of these five patients, however, two presented indications of return of the disease in the vaginal cicatrix. The authors point out that vaginal hysterectomy is a serious measure, as these tables show a death rate from the operation itself of about twenty-three per cent. The results of this treatment are, it is held, not more serious when it is performed as a palliative step than when it has for its object complete removal of the diseased structures. It is indicated, therefore, whenever the cancerous uterus is mobile, although the vaginal culde-sac may be involved in the disease. Recurrence, which has been noted in about seventy per cent. of the cases, although usually speedy, may in some cases be postponed for a long interval (from seventeen months to two years, or even longer). These tables show that thirty per cent. of the patients who had undergone vaginal hysterectomy are apparently cured by this operation, even in cases in which the malignant nature of the disease has been proved by both clinical and histological observation.