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ADDRESSES.

SOME MOOTED POINTS IN OBSTETRICS AND GYNECOLOGY.—PRESIDENT'S ADDRESS.

Read in the Section of Obstetrics and Diseases of Women, at the Forty-third Annual Meeting of the American Medical Association, held at Detroit, Mich., June, 1892.

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Gentlemen:—It is with particular pleasure that I come to preside over the destinies of this vigorous Section at the meeting of the Association in this the City of the Straits. The number of titles presented the Chairman to form a program demonstrated that the Association is not losing interest in the special work of this Section. It was found necessary to decline almost enough papers to have formed an additional list as large as the one we present.

In preserving the work of the Section, the plan instituted last year of printing the papers and addresses read before it in a separate volume, was a step in the right direction, but unfortunately it is rendered almost worthless by the absence of any index. The busy student, unless aware that it contains certain articles is not likely to scan its pages to ascertain whether it contains the particular knowledge he desires.

It is also unfortunate that we cannot secure and preserve the discussions which are called forth by papers presented—a discussion which frequently contains material more valuable than the paper or address from which it originated.

Through the assiduous enterprise of Dr. Manton, the Section will have the privilege of enjoying a special dinner, during which we will be able to become better acquainted and cultivate to a greater degree the social work of the Section.

In considering a subject for an address to this body, I felt I could more profitably employ your time by discussing some of the mooted points in obstetrics and gynecology than by the presentation of a paper upon any special subject.

It is true that some of the subjects I have chosen may seem trite, but it cannot be said they are unimportant, and unworthy of careful consideration.

It is with hesitancy I consider some, for the reason that they will be more extensively and ably discussed in papers that are listed for your appreciation.

Cæsarean Section versus Craniotomy.—Under cruder methods of procedure a comparatively low valuation was placed upon intra-uterine life. We need but to review the statistics of the earlier British obstetricians to see in how much larger a ratio the life of the child was sacrificed than resort was made to the use of the forceps. As this instrument was more frequently used, the number of instances in which it was found necessary to destroy the child was greatly

diminished. With the knowledge secured through the practice of antiseptic measures, the term of human life has been lengthened and the importance of the unborn individual has obtained a higher appreciation. The obstetrician more and more recognizes that in every case of labor, there are two individuals to be considered, each of whom must be afforded a chance for life.

In view of the safety of induction of premature labor, of the decreased mortality of the modified Cæsarean and Porro operations, it has become a serious question in the minds of many of our best practitioners, whether the living child should ever be subjected to embryotomy.

It is a source of continual opprobrium to our profession that we must sacrifice life to save it. With the reduced mortality of the Cæsarean procedure experienced by Zweifel (1 in 18), it no longer seems just that the life of one of the interested individuals should be destroyed. The responsibility of parentage, the obligation to the unborn, both of physician and patient, should have a higher standard of appreciation. We would urge that craniotomy in obstructions of the pelvis, only be elected when: 1, the child is certainly dead and its delivery unmutated would endanger the vitality of the maternal tissues; 2, the child still living, after repeated mechanical efforts to deliver, and the physical signs demonstrate that the child is too feeble to long survive its birth. The maternal peril should not be increased, or comfort lessened, when it is evident the child has no chance of surviving; 3, the existence of hydrocephalous or other irremediable disease in the fetus.

The choice between the Cæsarean and Porro operations has been much discussed. The advocates of the latter procedure claim that it lessens the danger, by the removal of the large absorbing surface of the body, obviates the escape into abdomen of fluid from the uterus and saves the patient from subsequent recurrence of pregnancy. Its opponents reply that an operation properly performed, should leave the cavity in as good condition as after an ordinary labor; the uterus, carefully sutured, quickly unites, rendering leakage into abdomen extremely improbable.

The prevention of subsequent pregnancy is not always desirable even in rachitic patients, as it has been recognized that their defects have no special influence upon the health of their offspring.

The danger in secondary Cæsarean operations is greatly lessened.

The statistics collected by Harris have demonstrated that this operation has not been attended with as favorable results as the modified Cæsarean. It is indicated in the presence of large fibroid growths, or where the patient has been long in labor and the uterus has become bruised and partially devitalized, or in the presence of beginning sepsis.

Placenta Prævia.—There is no condition, probably,

which has given greater anxiety or more varied discussion than the attachment of the placenta in the lower segment of the uterus. When we consider the danger to the individual arising from the progress of such a condition, it seems unwise to permit her to be subjected to it, if there is any possible means of its avoidance. Where it has been demonstrated that the placenta occupies the position known as centralis, what possible advantage can be urged in permitting the patient to go on to near full term with a possibility of recurring hæmorrhages, any one of which may prove fatal, before a physician can be secured. In such cases it is very rare for the child to be delivered alive, and consequently for the slight possibility there is of its being saved, the life of the woman should not be imperilled.

The better plan of treatment would seem to be that urged by Wyder. Secure dilatation of the uterus sufficient to permit of version by the Braxton Hicks method, then drag the limbs into the cervix, which will act as a natural tampon and prevent further hæmorrhage.

The writer was called some time ago to see a woman—the wife of a physician in Lock Haven, Pa. He arrived at 8 A.M., and found the woman had been suffering from repeated attacks of hæmorrhage. Placenta prævia had been suspected, the uterus was dilated sufficiently to permit the introduction of one finger; this was followed by a second, forcibly dilating the uterus until the two fingers were in its cavity, then the membranes were ruptured, by external manipulation, one leg of the child was brought in contact with the internal fingers and drawn into the cervix. By moderate traction the uterus was dilated, and the fœtus delivered; the placenta was removed, uterine contractions secured, and the vagina and uterus irrigated, all being completed in less than three hours. This patient had had two or three hæmorrhages previously, which had led to fears of her being unable to recover therefrom. She was exceedingly weak and debilitated. The child was still-born, the mother recovered without any untoward symptoms.

According to Wyder, the maternal mortality under the old plan of treatment reached 30 to 40 per cent., while the statistics of the clinics of Schroeder and Gusserow, in which the plan of treatment just considered was followed, the percentage of mortality was 6 to 7 per cent. The infantile mortality under the old methods was from 50 to 70 per cent. Under the new it was but slightly more, being but 70 to 80 per cent., and this mortality is of course compensated by the greatly reduced maternal loss. In addition to the advantage of relieving the patient and physician of every anxiety, it also decreases the danger to the patient from sepsis during the subsequent convalescence.

Sepsis.—The importance of early treatment of septic conditions cannot be too highly appreciated. When we consider the rapidity with which diseased conditions extend from the uterine mucous membrane to that of the tubes, and along the lymphatics subsequently involving the ovaries and peritoneum, we cannot urge too strongly the necessity of prompt measures to arrest the progress of the disease while still with the uterus. Infection of the uterine cavity leads to rapid development of inflammatory changes in the mucous membrane and to arrest of normal processes. Multiplication of germs in the mucosa

and repeated absorption of their products into the system, produces all the symptoms of septicæmia. The usual course in such elevation of temperature, is to proceed with frequent intra-uterine irrigation, thus endeavoring to obviate the unpleasant effects of the poison. The difficulty, however, in accomplishing this, or in rendering it thoroughly serviceable, is that we have the membrane of the uterus coated over with considerable debris, which is only superficially affected by the germicidal irrigation. Consequently we would urge the necessity, not only of irrigation, but of thorough curetting of the cavity, scraping away the broken down and infected tissue, doing this either with the blunt curette or with what is a still better instrument, the finger.

Having removed and loosened this tissue as thoroughly as possible the intra-uterine syringe should be used, taking proper precaution to secure a free flow of the fluid from the organ. The irrigation may be practiced by the use of a solution of acid sublimate or peroxide of hydrogen. Where the former agent is used, it should be followed by irrigation with sterilized water, so that the superfluous material which might be absorbed and poison the patient, will be washed away.

The thick, flabby walls of the uterus, lying in contact with each other, leads to blocking up of the uterine secretion in the cavity of the organ and thus promotes the tendency to putrefactive changes. To avoid this, drainage should be secured. It may be done by introducing a rope of iodoform gauze to the fundus of the uterus. This serves an excellent purpose first, in keeping the walls apart, second, it acts as a drain through its capillary action, and third, stimulates the processes of involution by its presence as a foreign body. Where the vagina and uterus have been thoroughly cleansed and prepared for its introduction, the twist of gauze may be left from 48 to 72 hours. Its removal should be followed by careful irrigation and the reintroduction of gauze. In this way the size of the uterus may be reduced to the normal, in a short time.

The serious effect of extension of inflammation from the uterus must impress on the obstetrician the great importance of early treatment. It has been the experience of the writer to have, in several instances, to consider the necessity of operative interference to save the life of the patient. In one instance repeated attacks of chill and fever occurring weeks after the uterus had been curetted and irrigated, led to opening of the abdomen and removal of the ovaries. In one of these a teaspoonful of stinking, greenish-yellow pus was found. The operation was followed by rapid subsidence of all inflammatory changes, and the recovery of the patient.

In another instance, a mass was found in the left side of the uterus, which proved to be a large pus sac and was removed, the patient recovering.

A case was recently seen in the practice of Dr. Parrish, of Philadelphia, in which an abscess had extended into the wall of the uterus. In this patient, one side of the uterus was cut away nearly to the cavity of the organ, the walls sutured, bringing the peritoneum over the denuded surface, and the patient fully recovered. In the presence of such possible results, the patient should not be permitted to go without the disease being attacked in its original site of development.

Endometritis.—In acute chronic inflammation of

the non-pregnant uterus, it seems just as important that diseased conditions, wherever possible, may be arrested while confined to the uterine cavity, and not permit their extension to inflammation of the tubes. The treatment in such diseased conditions becomes a serious question how we can best remedy it, and what plan of procedure is least likely to be attended with inflammatory extension. When we come to consider that the uterine canal, abraded of its ciliated columnar epithelium by the catarrhal processes, its glands, stimulated to greater activity, filled with viscid secretion, the mucous membrane of the uterus oftentimes covered with papillary masses, resembling polypi, the surface of the entire canal resembling greatly that of an ordinary sinus, it seems but prudent that every precaution should be taken to correct the condition as early as possible. Here, as in every other sinus, it is important to secure thorough and prompt drainage. The proper plan of procedure then would be, after thorough aseptic precautions, the dilatation of the uterus, curetting of its cavity, washing it out with a disinfectant solution, and then the application of some means to secure drainage. This may be done either by the method of Polk, or that of Wylie and Boldt.

Polk packs the cavity of the uterus with iodoform gauze, trusting to its influence on the mucous membrane to bring about more rapid activity of the uterine circulation, and consequently decrease in the size of the organ. The grooved stem pessaries of Wylie and Boldt also increase the activity of the circulation and promote drainage. These instruments may be worn for some length of time, and under their influence the uterus will become rapidly involuted.

Trendelenburg Posture.—In the various operations upon the pelvic organs, the majority of operators have followed the lead of the pioneers in this field, and placed the patient in the horizontal position. This posture of the patient has, however, been attended with a number of disadvantages. First, the difficulty of illuminating the pelvis and being able to see into the deeper cavity, and thus secure bleeding points. If the operator, having in many cases to depend upon the touch to determine the condition of the broad ligament, should through any misfortune let the ligature slip, allowing a vessel to spurt, quite severe hæmorrhage can take place before he will be able to determine its origin; second, the intestines are very likely to be pushed out of the wound, are retained with difficulty and still further obscure the pelvic cavity. The posture known as the Trendelenburg, and which has been ably advocated in this country by Dr. Krug, of New York, aims to place the patient in a position in which the lower part of the pelvis is elevated at an angle of 45° to 60° ; this done in front of a window, permits the light to fall directly into the pelvis when the wound is held open, and at the same time causes the viscera to fall upward toward the diaphragm, preventing them from obscuring the vision. In this posture, the physician and attendants are enabled to look directly into the pelvis, and see the bladder and uterus, the appendages, the existence of adhesions and the relations of the pelvic and abdominal viscera. If coils of intestine are adherent, these points are seen, the enucleation can be accomplished under the eye, and the extent of the involvement readily recognized. If bleeding occurs during the progress of the procedure, it can also

be seen, and the bleeding points promptly secured. It has been objected to the plan, that there is great danger of soiling the upper portion of the abdominal cavity with pus; but if the operator is careful in placing sponges around the pus cavity, it can be entirely prevented. Indeed, the intestines can be pushed upward, covered over with sponges in such a way that there is no possibility of any soiling of the peritoneal cavity above the abscess itself.

The cavity thus being freed from contact with pus and blood, the field of operation directly under the view, there is not the same necessity for abdominal irrigation that there would be where an abscess cavity is broken up, and pus flows upon the loops of the intestines and over the entire pelvis and its contents. The position is one that is of great advantage in every operation involving the removal of the uterine appendages. It is almost indispensable in those operations in which the entire uterus is removed through the abdomen.

Hysterectomy versus Supra-vaginal Hysterectomy in Fibroid Growths.—The extra-peritoneal treatment of the pedicle in the removal of fibroid tumors of the uterus has long been recognized as the most effective method of controlling hæmorrhage from the stump. The elastic character of the uterine tissue has been such that the majority of operators have hesitated to trust the ligature to control hæmorrhage in these cases. The extra-peritoneal treatment of the stump, however, has been attended with a very great deal of disadvantage. Not unfrequently the stump is necessarily a short one, the traction upon the vagina and pressure against the bladder is marked and distressing, the size of the stump, filling up a large portion of the lower angle of the wound, necessarily produces a weakened ventrum, and the pressure of the pins upon the abdominal surfaces resulting from the traction of the stump, not unfrequently leads to ulceration. The retraction of the stump following removal of the serre-nœud produces a large cavity, which must heal up by granulation, and thus delay the convalescence of the patient. For this reason, there has been a constant effort upon the part of the profession to avoid the necessity of extra-peritoneal treatment of the stump.

As we have already mentioned, the mortality of intra-peritoneal treatment has been disproportionately large. When we consider that this stump is of no special value and can be so easily removed, it seems singular that it has been permitted to remain so long. To accomplish its removal, however, the better plan of procedure is that instituted by Krug, which consists in throwing about the stump an elastic ligature, or applying a clamp temporarily to the cervix, cutting off the tumor and then opening into the vagina posteriorly, and following this by the separation of the bladder anteriorly until the vagina is reached and the broad ligament ligated on each side, in sections.

To perform this portion of the operation, the Trendelenburg posture is of very great advantage. Krug ligates with silk, leaves his ligatures long and draws them out through the vagina, in this way inverting the edges, while he depends upon drainage by packing the vagina and lower part of the abdomen from above with iodoform gauze. This is withdrawn at the end of a week through the vagina. With this part of his procedure, however, I am inclined to dissent, preferring to ligate the broad ligaments with

catgut ligatures which shall be cut short, and then following the procedure suggested by Reed, of suturing the peritoneum over the upper part of the vagina, shutting it off from the peritoneal cavity.

In those cases in which the peritoneum cannot be entirely brought together, and there has been considerable denudation, the vaginal opening may be closed and drainage accomplished by the glass tube, or the gauze twist brought out at the lower angle of the wound. The advantage of such a procedure, leaving the stump, is that the wound will close in a short time, and we do not have the depressed granulating wound to delay the subsequent convalescence and to leave a weakened ventrum during the after years.

Sacral Resection.—Kraske, in 1885, pointed out the accessibility of the middle part of the rectum by a posterior incision, removing the coccyx, and part of the lower two segments of the sacrum. Hochenegg and Herzfeld have demonstrated the application of this procedure to some of the gynecological operations. When we consider the position of the uterus in the pelvis, we can but recognize that the shortest distance to it is directly through the lower end of the sacrum. The application of this operation to gynecological work is necessarily limited, but it is none the less of interest as a method of procedure in some cases which offer complications by the ordinary plans of operation.

The writer has reported two cases in which this operation has been performed for the removal of the uterus. In one the condition was complicated by cancer of the middle part of the rectum, involving the upper part of the posterior wall of the vagina and the cervix. In the operation about 3 inches of the rectum, the upper part of the posterior wall of the vagina, the uterus and ovaries were removed. The patient recovered from the operation, but succumbed six months later from a return of the disease.

The second case occurred in a nulliparous woman, who had epithelioma of the cervix, complicated by a previous inflammation of the tubes and ovaries which had bound them down posteriorly to the uterus. It is recognized that the ordinary vaginal hysterectomy in an undilated vagina, with the uterus, ovaries and tubes bound down by adhesions, would be an exceedingly difficult procedure.

In considering the case, he concluded to perform the operation by sacral resection in preference to opening the abdomen from above. The result was exceedingly gratifying; the tubes were easily reached, readily ligated, the vessels could be seen, the relation of the ureters to the uterus determined, and the organs accordingly very readily avoided. The method of performing the operation has been so thoroughly described in recent publications, that it does not seem necessary to occupy your time further in its description.