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Removal of the Uterus and Its Appendages for Pelvic Inflammatory Disease.¹

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It was supposed when we had all learned the lesson that Mr. Tait fought so long and valiantly to teach us, that the question of the treatment of pelvic inflammations and their ravages had been finally settled. The removal of the displaced and adherent Fallopian tubes and ovaries, which contained pus or whose tissues were hypertrophied and infiltrated with chronic inflammatory products, soon became a common procedure and the technique of the operation was so rapidly pushed to perfection that many operators arose whose results successfully rivaled those of Tait himself. Large numbers of women who had formerly been doomed to a hopeless invalidism were now restored

to health and useful lives. So frequently were these happy results obtained and reported to an expectant profession that sight was lost altogether, for the time, of certain cases, afflicted with these same diseases, on whom the same operation had been performed, but who were not blessed with the same good results as their more fortunate sisters. The glamor of success of an entirely new and brilliant procedure so greatly overshadowed these poor sufferers that time was necessary before attention could be directed towards them. As is often the case the enemies of the new procedure were the first to point out this class, not from any particular desire to aid in the complete solution of the problem, but from a spirit of criticism which says, "Lo and behold!

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thy vaunted remedy has failed." It had failed to a certain extent, it is true, and the taunt sufficed to draw closer attention to the failures and a deeper study as to why they had failed.

You are all of you cognizant of patients in your practice on whom an abdominal section has been performed for pelvic inflammatory disease, who consults you for continued bleeding, leucorrhœal discharges (often profuse) and pain—women who have had the operation performed for these symptoms and who complain now, three months, six months, a year after the operation, of the same kind and the same amount of suffering. You are familiar with such cases, coming both from your own practice and that of your neighbor. They come into the public clinics in considerable numbers complaining of the operator and refusing to return to him for the reason that they had thought the operation would cure them, and because it had not their doctor was to blame, as usual, and as a matter of course. These are the same patients who are held up to us as a proof that our method of treatment is wrong and has failed and should, therefore, be condemned in toto. The time has not even yet passed when we must submit to just such spurious criticism.

But, as a matter of fact, a certain too large proportion of our patients still remain uncured by a simple removal of the uterine appendages; and let me emphasize the fact that I am now discussing a class of patients who have an easily demonstrable amount of disease of these organs—no reference is intended to that too numerous class on whom operations

are performed for symptoms alone, no disease being found by a physical examination and none capable of clear demonstration even after the organs have been removed.

Local applications to the uterus after a cœliotomy for removal of the appendages has been tried, with no greater success than the same amount of treatment before the surgical procedure. Curettement of the womb has been followed with little more encouraging results. I have adopted this course in some six or ten cases, and have not been able in a single one to say that I had cured the woman. The majority of them ceased coming for treatment long before any decided result had been obtained. During the past winter it was my misfortune to see a number of these women who had been unrelieved or only partially relieved in spite of the fact that a complete and clean removal of both appendages had been made and that the remaining uteri were freely movable. No trouble could be detected in the pelvis by a most careful and repeated physical examination.

After applying local and general treatment to several of these women, until we were both discouraged and disgusted, I, in despair, suggested that the womb itself be removed. I was led to this decision from the fact that I had known some months before of a case on whom my colleague, Dr. Baer, had performed several abdominal sections in, I think, a neurotic case, without obtaining much relief, and upon whom he had finally performed hysterectomy with an extremely satisfactory result. This, in addition to the work being done in France in the way of hysterectomy

for pelvic abscesses, evidently influenced my thoughts in this direction. The woman to whom I proposed the operation had had her original operation for suppurating uterine appendages. Months after her operation she still had a large uterus, irregular bleeding, profuse leucorrhœal discharges, great backache and pelvic bearing-down pains. The uterus was removed by supra-vaginal amputation low down into the cervix, and dropping the stump back into the pelvis. Her recovery was an uninterrupted one. The bleeding and leucorrhœal discharges ceased at once, and the pelvic pains and backache almost entirely disappeared, the little that remained of them being evidently due to the menopause. Encouraged by this result, I have continued this line of treatment up to the present time, and have now had sufficient experience to feel warranted in recommending the procedure to your careful consideration and trial. In two cases have I removed the uterus subsequent to a simple removal of the appendages. Six times have I removed it at the primary operation.

It is well known that in pelvic inflammation the disease first affects the womb, and secondarily invades the Fallopian tubes and the pelvic peritoneum. Not only is the endometrium affected, but the inflammatory products invade the deeper structures which go to make up the uterine walls. If a suppurative process follows, these infiltrates undergo the same changes as do the same elements in the walls of the Fallopian tubes. The ease with which a ligature cuts through uterine tissue, when applied at the cornua in cases of pus tubes, is a well-known demon-

stration of the truth of this. With a Fallopian tube and uterus, both of which are diseased by the same factor and to the same extent, is it rational to suppose that a cure is to be always obtained by the removal of the tube alone? Is it not common sense to remove the whole of the disease, and not only a part? Theory and practice both combine in this matter to force the conclusion.

It must not be understood that I recommend the removal of the uterus together with the Fallopian tubes and ovaries in all cases of pelvic inflammatory disease. In many cases the uterus has succeeded in throwing off the original infection, and is comparatively healthy. Under such circumstances the procedure is not indicated. But where an abdominal section is performed for the removal of the uterine appendages, and the womb is found enlarged and diseased, especially if it has been surrounded by extensive adhesions, and the freeing of it leaves large areas of diseased peritoneum, hysterectomy should be the operation of choice. But a single objection can be raised to this proposition, viz., the mortality of the operation. Can, then, hysterectomy be performed as safely as ovariectomy? Unhesitatingly I answer in the affirmative. My own hysterectomies now number more than eighty, with seven deaths. These deaths include the accidents incident to acquiring the skill and perfecting the technique; in a similar series the results will be infinitely better.

Beyond the question of mortality there can be no doubt as to the advisability of removing the diseased uterus. With its appendages gone it is an altogether useless organ, and

even the old, familiar cry of mutilation and unsexing the patient has no place.

I am free to confess that since adopting this method of practice the field for hysterectomy has greatly widened. For instance, I assented and assisted in an operation for the removal of the uterus in a woman upon whom seven abdominal sections had been performed without giving her relief. The uterus was enlarged, and was found to contain several small fibroid nodules, as large as a hickory nut, which had undergone calcareous degeneration. The patient was relieved at once, and continued so for some months, when she disappeared from observation.

Only last Sunday I performed an abdominal section for double ovarian cysts. One cyst proved to have grown into the broad ligament, while

the second one was free. The uterus was very large, half as large again as normal. The operation was finished by making a clean sweep of both tumors, Fallopian tubes and uterus. The patient is convalescent, and is, I think, distinctly better without the womb, which I exhibit to you.

Looking at this matter as I do, it has been no great matter of surprise to me to find other operators adopting this procedure. Last spring, while visiting in New York, I found that Krug had arrived at much the same conclusion, and was following a like practice. During a recent visit to Chicago I discovered that Heurotin was working on the same lines, and I have no doubt but that after a winter's agitation on the subject most of the profession will be won over to a similar manner of thinking and to the same practice.