

PRICE (Jos.)

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PRESENTATION OF POST-OPERATIVE SEQUELÆ AND
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By JOSEPH PRICE, M. D., PHILADELPHIA.

It would be difficult to settle the relative merits of some of our gynæcological operations by statistics ; but few operators give every patient the one remaining chance for her life, refusing nothing. A good number of operators select their patients and operations most carefully, excluding some on the ground that their general condition, heart, kidneys, or lungs are faulty, and that they will not bear an operation ; second, that the trouble is malignant or too adherent or complicated by visceral attachments. These are the cases that they do not even attempt. In the next group they explore by abdominal or vaginal incisions or punctures by trocar or aspirator, and again declare them inoperable—only proper subjects for palliative methods of treatment. It is to the last group of cases I desire to particularly call your attention.

We all know how common it is for these patients to drift from one operator to another. About all these patients continue to suffer and demand radical measures at the hands of some one else. The operator, willing and capable of completing these operations, finds them thrice more complicated than the same class of troubles before incision or puncture—the patients exhausted from prolonged drainage, septic from imperfect drainage, renal and hepatic disturbance due to the prolonged and neglected suppuration, shock more prominent and unavoidable, and due chiefly to severing anchored cicatrices at the seat of incision or puncture.

Aside from shock and hæmorrhage, the risks of contamination of viscera and wound are increased. Again, viscera lesions are multiplied, their repair much more complicated and uncertain. Completed primary work by the suprapubic incision gives the lowest mortality, the

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most speedy recoveries, and the fewest post-operative complications or sequelæ. Sinuses at any point above or below, due to either ignorance, neglect, or delay, are both distressing to patient and physicians interested; two or more surgical efforts are necessary to cure or save. With this knowledge, why should we timidly and deliberately favor such complications in healthy, favorable subjects for complete work by timid operations? Opening the abdomen, stitching abscess or sacs, to incision or packing around about with gauze, to incise later for drainage and irrigation! The enucleation of such abscess and sacs is easy, safe, and sure, and if viscera is involved, careful freeing and repairing, if necessary, results in what we most desire—a cure.

It would seem by some recent papers and discussions that a reversion to ancient methods of treatment had taken root at some points. Present efforts at the choice and selection of the so-called proper cases is to be condemned. It results in the neglect of many patients, and increases the mortality by favoring late operations in the hands of men willing and capable and possessing a decent surgical conscience. The doing of refused, incomplete, and abandoned operations is a trying discipline to one familiar with pelvic and abdominal disease in its early natural history.

Years ago the operations for pelvic disease were much easier—less complicated than at present. In a large group of operations in my own hands done very recently, about everything adjacent to the pelvic inlet from appendix to sigmoid, appendix, cæcum, ileum, sigmoid, and omentum had been strongly anchored to the underlying specimens. The last four operations, done in the last four days, were full of positive complications, contraindicating vaginal methods of treatment. Again, while the fixation of large pus tubes and ovarian abscess are very great, they are just the cases to demonstrate the importance of complete methods by the suprapubic incision. All of them had been tinkered with for many years. It was not necessary “to back down” or abandon any of them for the modern incomplete methods, and I unhesitatingly urge the importance of a more careful study of the pathology and adhesions of tubal and ovarian disease, the diagnosis and the simplicity of the completed suprapubic methods of removal. I do this that the general practitioner may not be led astray and criticise us in our general disagreement in methods and results.

