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THE COMPARATIVE VALUE OF CELIOHYSTEROTOMY AND CELIOHYSTERECTOMY IN CASES REQUIRING A CESAREAN SECTION.

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THE impression prevails among physicians in general, I think, that the classical conservative Cesarean section is a safer and better operation than the Porro-Cesarean section or the removal of the uterus after the extraction of the child. On entering practice and for some years afterward I entertained this view, believing that hysterectomy should only be performed when a woman had been very long in labor and many futile attempts at delivery had been made, probably infecting the endometrium; if there was uncontrollable hemorrhage from uterine atony; in case of such insuperable obstacles to drainage of lochia as a cancer of the cervix or a bony tumor of the pelvis; or in the presence of a uterine tumor which could only be removed with the womb. Experience has compelled me to change my mind and to regard celiohysterectomy in a case requiring Cesarean section as the preferable operation, with a lower mortality and a greater freedom from complications, not only in the puerperium, but in the patient's future existence.

It is easy to understand the prejudice against the Porro operation and in favor of the classical Cesarean section, if one recalls the history of abdominal and uterine section for the termination of insuperably obstructed labors.

During the first two hundred and sixty-six years in which Cesarean section was practised upon the living woman the mortality of the operation had been so frightful that any expedient to avoid it was thought justifiable. Induction of abortion for a deformed pelvis, symphyseotomy, laparo-elytrotomy,

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653

each had its origin in a desire to escape the dangers of Cesarean section, while for the same reason much ingenuity was devoted to the improvement of the technique and to the invention of new instruments in the oldest obstetrical operation—embryotomy.

Finally, in the spring of 1876, Edward Porro performed the first successful celiohysterectomy for obstructed labor. This method of operating so obviously avoided the most fatal dangers of the older plan that it was widely adopted, and in the hands of such men as Carl Braun, Breisky, Leopold, Krassowsky, Frank, Fehling, Tait, and Porro himself, the mortality of Cesarean section was reduced to less than half of what it had been. Scarcely, however, were these results beginning to be appreciated by the medical world at large when Sänger proposed the close and accurate suturing of the uterine wound, including the peritoneal covering. Coincident almost with the adoption of this great improvement in the operation there began the aseptic era in abdominal surgery and the appreciation of the common-sense rule that Cesarean section, when required at all, should not be postponed until the patient is at the last gasp, after every other means of delivery had been tried in vain.

By a combination of the three factors—close suturing of the uterine wound, aseptic technique, and early operations—results were secured of such brilliancy as to throw the achievements of Porro and his followers completely into the shade. Meanwhile, however, Cesarean section by celiohysterectomy has undergone an evolution from which the attention of the profession has been distracted by the glamor of the results following the Sänger operation. All gynecologists are familiar with the improvement in the technique of hysterectomy which has made the intraperitoneal treatment of the stump a much safer as well as a much more satisfactory method of operating than the extraperitoneal fixation of the cervix used to be. I had an opportunity of witnessing one of Dr. Baer's early operations by this method, and immediately adopted it in my next Cesarean section, which, it is my impression, was the first to be performed by this technique in America. In the past six years a number of Cesarean sections followed by hysterectomy have been performed by the best and most modern technique, ligating the arteries of the broad ligament, dropping the cervix and sewing over it a peritoneal flap. It is too soon, however, to collect statistics of this operation and to compare its results

with those of celiohysterotomy. There are disadvantages, moreover, in the mere statistical study of any subject which the practical worker has often reason to appreciate. Without an array of figures, therefore, to support my statement, I can say from my own experience that not only does it add nothing to the danger of a Cesarean section to remove the womb, but, on the contrary, it diminishes the risk of the operation, for it eliminates the possibility of postpartum hemorrhage and lessens enormously the chance of puerperal infection. Certain complications in the puerperium also, as well as others at later periods in the individual's life, are surely avoided by a hysterectomy. These are: retention and decomposition of the lochial discharge, to which the undilated cervical canal does not give free vent if the operation is performed before labor; adhesions between the anterior uterine and abdominal walls; persistent fistulæ communicating with the uterine cavity; rupture of the uterus in subsequent pregnancies and labors; and the necessity for repeated Cesarean sections if the woman is allowed to become pregnant again.

If these incontrovertible facts are taken into consideration, it must be patent to any one that the statistics of the future, studied with discrimination, and taking into account the woman's life history, will demonstrate the superiority in results of the modern Porro operation over the conservative classical Cesarean section.

Whatever one's predilection may be in favor of hysterotomy or hysterectomy, he will admit that certain conditions in parturient women forbid a freedom of choice and compel the selection of the latter operation. It is interesting, therefore, to study the proportion of cases, if only in the light of one physician's experience, in which the Porro operation must be performed and a mere hysterotomy should not be relied upon.

My experience in Cesarean section now amounts to twenty operations, performed for the following indications: fibroid tumors, two; dermoid cysts impacted in pelvis, two; cancer of the cervix, one; partial atresia of vagina, one; contracted pelves, fourteen, of which there were one kyphotic pelvis, one obliquely contracted and flat, one transversely contracted, eleven flat rachitic. Out of this number I should have been compelled to perform a Porro operation, no matter what my preference may have been, in eleven cases. In six of the operations for contracted pelvis the patient had been in labor many hours. Futile attempts at delivery had been made with

forceps, and in two instances by craniotomy. The uterus was already infected, and the birth canal injured by slipping instruments or by the exercise of unjustifiable force in efforts at extraction. In one of the cases of impacted dermoids the woman had been in labor four days. The pelvic connective tissue and lower uterine segment were extraordinarily edematous, and the endometrium was almost black in color. In the two cases of fibroids attached to the lower uterine segment a hysterectomy was necessary to remove the tumors. In the cases of atresia of the vagina and of cancer of the cervix it was obviously improper to leave the womb behind.

If I may be permitted to judge by my own experience alone, it appears that a Porro operation will be absolutely required in practice a little more frequently than a Sänger, and it seems clear to me that this experience represents about what may be expected by any one who may be called upon to perform these operations. The cases have been distributed over a period of ten years. The women have come to me from all sorts of sources. One case only occurred among my own patients; the others have been referred to the various hospitals with which I have been connected, have been brought to me in emergencies in cabs and ambulances, have been specially referred to me from a distance, or I have seen them in their own homes at the request of their physicians.

It seems fair to assume, therefore, that any one in a position to receive such patients, any practitioner at a distance from expert surgical aid who may have such an operation thrust upon him at a moment's notice, should be prepared at least as often as not to perform a modern hysterectomy as a part of a Cesarean section.

As a matter of fact, among the twenty operations cited above, seventeen have been hysterectomies and only three hysterotomies, and I am convinced that this is about the numerical relation the two operations should bear to one another. Whether the womb should be removed in the great majority of cases, however, depends entirely upon one's viewpoint in regard to the justifiability of repeated pregnancies in women who can only be delivered by a Cesarean section. On this matter I am perfectly clear in my own mind. I could not reconcile it with my conscience to condemn a woman to the probability of a repeated Cesarean section unless she herself and her husband demanded it. This, however, is a remote contin-

gency. In every case in which the matter has been submitted to the patient or her friends, I have been urgently requested to prevent the possibility of another conception. The arguments of those surgeons who advocate a different plan are, of course, entitled to and certainly receive from me respectful attention, but they are, in my judgment, inconclusive. I read, for example, in one debate upon the subject, the remarkable statement that a physician must take into account only the present condition; that it is nothing to him if his patient becomes pregnant in the future, even though a Cesarean section is again required. As if a physician or surgeon should ignore the future comfort, happiness, or safety of his patient, so long as he extricates her from a present difficulty. Luckily the general level of medical intelligence, conscientiousness, and foresight is higher than it would appear to be if such a statement really reflected professional opinion.

Another participator in this same debate claimed that there was no reason nowadays for avoiding a Cesarean section, as the mortality of repeated operations was scarcely greater than that of natural labor. And yet I happen to know that this operator's mortality in the operation has been thirty-three per cent. Even if it were possible for the most skilful and experienced operator, dealing with a patient in the most favorable condition and amid the best surroundings, to eliminate the dangers of Cesarean section, it would still be impossible to be certain that a woman would on the next occasion be so situated that she could command the best attention. Hence Cesarean section is and will remain a dangerous procedure with a considerable mortality. It has to-day, in this country, a death rate of about forty per cent, taking into account all the operations of which a record can be procured, and the statistics have not improved in recent years.

The history of a patient referred to me last autumn for a Cesarean section well illustrates, I think, the fate in store for many women who can only be delivered by uterine section. She had given birth to two or three children previously with the greatest difficulty, even after embryotomy, and her physician told me she could not, in his opinion, survive another such operation as he had been compelled to perform the last time. I found a rachitic pelvis, with a conjugate of about seven and three-quarter centimetres or a little less, and an overgrown child, the head of which, even at the seventh month, could not

be pressed into the superior strait. The woman stated that her other children had all been overgrown at birth, none of them, she said, weighing less than twelve pounds. As she and her husband desired a living child, I recommended a Cesarean section at term. This recommendation was accepted by the family physician, the husband, and the wife, after careful consideration. The patient accordingly entered the University Maternity to await the date of the operation. Unfortunately she grew very homesick and begged me to allow her to return home, if only for a week, promising faithfully to return to the hospital in good time for the operation. I cautioned her against staying away long, pointing out to her the difficulties and dangers of her former labors, and warning her not to run the risk of falling in labor in the small town in which she lived, where she could not obtain the skilled attention that she needed, and whence she could not perhaps be transported to the city in time. She seemed to be impressed by what I said, and I had no doubt she would return. As it appeared later, however, she was not only homesick but frightened, and when she left the hospital she evidently determined not to come back. On her return home she failed to notify her physician, and deliberately kept him in ignorance of the fact that she was in labor till she had had hard pains for thirty-six hours. The os was then dilated, and her physician thought it too late to send her to the city. He was led to believe, moreover, that there was a chance for spontaneous delivery, as the head appeared to be descending the pelvic canal; but he was deceived, as many another has been, by a steadily increasing caput succedaneum and the shallow pelvis of rachitis. While he was awaiting further progress the woman ruptured her uterus and died with the child undelivered. Now, this woman had considerable intelligence; she had had a practical demonstration of the dangers of delivery by the natural passage in several dreadful experiences of inordinately delayed labors, prolonged anesthetizations, difficult embryotomies, and complicated convalescences; she had been impressively warned never to incur the risk of delivery by the vagina again; her physician and her husband had urged her to have the Cesarean operation performed and she had consented; yet she deliberately chose to accept the risks of another difficult labor, either because she thought the Cesarean section was unnecessary or was afraid to undergo it. What is to be expected, therefore, of the more ignorant hospi-

tal patient? She has a Cesarean section performed, say in her first pregnancy or labor. She recovers from the anesthetic and finds herself safely delivered without any difficulty to herself and with very little suffering afterward. She is told that she can never have a child in the natural way and must always be operated upon in subsequent labors. It is doubtful often if she believes it or whether she will remember the warning; or she may be so placed that it is impossible for her to secure the services of an expert; so that her next labor will find her not improbably in the slums under the care of a midwife, or of a physician not much better informed as to contracted pelves, and her life will very likely pay the forfeit.

Taking into account, therefore, the unavoidable though small mortality of Cesarean section under the most favorable circumstances; considering, moreover, the impossibility of always securing the best circumstances in many cases, it seems perfectly clear to me that it is unjustifiable to subject a woman with an insuperably obstructed pelvis to the dangers of subsequent pregnancies and of a repeated Cesarean section. Once this point is conceded it is unnecessary to argue further for a hysterectomy. No one can contrast in actual practice the greater facility and rapidity with which a Porro operation can be done, the entire freedom from many of the risks of the puerperium after the removal of the womb, the impossibility of many complications that are likely in the Sänger operation, without preferring the former to the latter operation.

One argument that has appealed to me more strongly than any other against hysterectomy, and that would influence me had I not found its answer in my own experience, is the disadvantage of the early artificial menopause, the symptoms of which are rather more annoying, I think, after a hysterectomy than they are after a simple oöphorectomy. But there is something in the function of lactation which seems to neutralize the effect of the removal of the sexual organs. I have been many times struck with the absence of the disagreeable phenomena in the woman who nurses her child after a Porro operation. Nor do these symptoms appear later, for by the time the child is weaned the system is adjusted to the absence of the uterus and ovaries, so that the woman experiences none of the troubles usually incidental to the artificial menopause.

In still another direction the consequences of puerperal hysterectomy differ apparently from those which follow the opera-

tion at other times. We have all, I dare say, had reason to deplore in some cases the contraction of the vagina and the entire loss of sexual feeling which are occasionally observed after a hysterectomy, say, for a fibroid tumor. It is always difficult to obtain information about these matters, but as far as I can learn there has not been such a result after any of my Porro operations.

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