THE DEGENERATION OF GYNECOLOGY.[1]

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SURGERY has been called the opprobrium of medicine; and if we may consider surgery and medicine as separate entities, this dictum in a sense is certainly true, for medicine only invokes the aid of surgery when it has acknowledged its own defeat. In the same sense, if we may separate the two, we must consider pelvic surgery the opprobrium of gynecology; for it is, or should be, only when gynecology fails that pelvic surgery is invoked.

[1]Read before the Washington Obstetrical and Gynecological Society, April 19, 1902.

If surgery is the opprobrium of medicine, it is equally true that amputation is the opprobrium of surgery, and that pelvic surgery, with its numerous amputations and "ectomies," is the opprobrium of opprobriums. Therefore the gynecologist who becomes a pelvic surgeon degenerates as a gynecologist. He acknowledges his inability to cure without resort to the opprobrium of opprobriums. All of us who were in practice fifteen years ago remember the days of so-called "tinkering" at the uterus and pelvic organs, when women came week after week, and month after month, for bi-weekly or tri-weekly treatments at the offices of gynecologists; and we recognize the change in the methods now in vogue, whereby such patients are promptly curetted, relieved of their appendages, or otherwise rapidly and radically cured—or buried. And though the pendulum has swung back to some extent from the operative furor of a few years ago, when we first learned to remove ovaries with comparative safety, and though there is now no wholesale removal of healthy organs, still the field of gynecology is nearly covered to-day by the pelvic surgeon, and non-operative gynecology has degenerated into a shadow of its former self. Is this degeneracy the atrophy of a useless art, or is it the result of neglect for more brilliant and showy methods?

Many complex questions arise in this connection, some of which I shall present for your consideration and discussion. For the sake of convenience I shall restrict the term gynecology so as to exclude all operations except plastic and minor work done through the vagina, and all major operations, whether done by the vaginal or abdominal routes, will be included under the head of pelvic surgery.

There can be no question that the perfection of pelvic surgery is a blessing to many suffering women; but it has been, and is now being, invoked in some cases where it is not needed and where it may prove a curse. We have learned many important truths from the rich store of experience in the past decade, but have we read aright and fully all its lessons? We have learned not to remove healthy ovaries, but have we learned that many diseased ovaries and tubes do not need removal? Experience has plainly shown us this fact. It has shown us that there are many varieties of diseased adnexa, some of which, even though very grave, require neither removal nor patching up. Surgery has shown us what havoc pus can create in the pelvis; but Nature has also shown her marvellous powers of reconstruction. When

first the surgeon became familiar with the gross organic lesions of parametritis as viewed through an abdominal incision, no wonder he thought them beyond the reach of anything but the amputating knife. But larger experience has shown him that Nature, properly assisted, may do what the knife cannot—heal without destruction. He has learned, by forced experience in cases that refused operation and in cases that were too ill for radical operation, that Nature may perform the apparently impossible task of completely restoring some of the worst pelvic inflammations, even where pus had formed.

I shall never forget a case I saw with Dr. Atkinson about six years ago. This young woman had a severe metritis and parametritis following a criminal abortion. The uterus was large, boggy, and fixed, the vaginal vault was everywhere hard and thick, and the whole abdomen tympanitic. She had had a high septic fever for six weeks, and, while we had no doubt that there was a large quantity of pus in her pelvis, we agreed that her general condition was so bad that no operation could be done. I fully expected her to die within twenty-four hours. But she recovered without any form of operation and without the discharge of any pus either through the vagina or intestine, and her recovery was complete. I examined her carefully two years later and could detect absolutely no sign of disease or abnormality. I have seen many similar cases, but none quite so striking.

There was much to condemn in the old tinkering gynecology, but there was much also that was good that is worth preserving and improving; and when our eyes are less dazzled by the brilliancy of operative measures, and we turn to account the new light gained from operative treatment, we will get better results than in the past, when pathology was dark and the benefits of rest, drainage, heat, and many other valuable therapeutic measures unappreciated. The lesson we now have to learn is this: what cases may be cured without operation, or with minor operation, and what cases must go to the pelvic surgeon. The principal gynecological diseases may be roughly divided into a few classes as follows: tumors, congenital malformations, dislocations of pelvic organs, lacerations, and inflammations acute and chronic. We all agree that tumors and lacerations require appropriate surgical treatment. The other classes I shall briefly consider.

Acute inflammations, unless I have read very badly the lesson

of the past ten years, should be taken from pelvic surgery and restored to gynecology. On November 6, 1896, I read a paper before this Society on the "Treatment of Acute Salpingitis," in which I endeavored to show that thorough and systematic treatment of this condition in its earlier stages would usually bring about resolution and recovery; that even when pus formed it should be evacuated per vaginam; and that in this way we could almost invariably, by safe palliative measures, tide the patient over the acute stage, and perform a radical operation later, if necessary, with comparatively little danger. Further experience has confirmed and extended these views, and I now believe that the radical operation will seldom be found necessary if proper treatment is continued, and that equally good results may be obtained in nearly all acute parametritic inflammations. There are several points in the treatment that I would emphasize:

1. *Rest.*—The importance of absolute rest in bed can hardly be overestimated. As long as there is hope of resolution, the patient should not be allowed to get up to evacuate the bowels and bladder, nor be propped up in bed, but should be made as comfortable and kept as cheerful as possible, so as to conduce to mental as well as physical rest.

2. *Nursing.*—A good trained nurse is invaluable in these cases. She can enforce rest, cheer and entertain the patient, keep her clean and comfortable, and in many ways increase her chances for recovery, besides carrying out the treatment ordered.

3. *Food and General Medicine.*—I think far too little importance has been attached to this part of the treatment. With increasing knowledge of Nature's methods of dealing with invading bacteria, we recognize more and more the importance of the part played by the leucocytes and blood serum. We look to these agents to perform the actual work of repelling the invaders and bringing about resolution. But no laborer can perform his best work upon a short ration, and it is a matter of first importance to supply the blood cells with the best possible ration in the form of rich serum. As our only ways of enriching the blood serum are by increasing digestion and checking waste, it becomes apparent that digestants and digestive stimulants, such as hydrochloric acid, pepsin, strychnia, and alcohol, may play no small part in the final result. The food should be of the most nourishing and easily digestible kind, and the quantity limited only by the ability to digest. Proteid food, beef, eggs, milk, etc.,

should be the chief reliance; but great care and judgment are necessary in regulating the quantity and frequency in individual cases.

It is also necessary to prevent the blood from becoming charged with excretory poisons, as far as possible, by keeping the bowels open and the skin clean. The bowels should be moved freely at least every other day by salts, calomel, or enema. It is of great value in the beginning to keep the bowels a little loose with repeated small doses of salts. Opiates should not be given unless, during the formation of an abscess, the pain is so great as to demand them, and then only until the abscess can be located and opened. Such abscesses can usually be opened quite easily under eucaine anesthesia. As a rule, pain is controlled by rest and local treatment.

Complicating diseases should be looked for, and appropriately treated if found—particularly syphilis, malaria, and grippe. I believe that many acute inflammations of the ear, pleuræ, abdomen, and pelvic organs may be traced to grippe as an exciting cause, and that such inflammations frequently go on to pus formation. The salicylates, particularly salicylate of cinchonidia, do much good in such cases.

4. *Local Treatment.*—Thorough uterine drainage should be at once established and maintained. I do not consider gauze drainage effective, and prefer the Outerbridge drainage tubes for this purpose. These tubes can usually be inserted without difficulty or pain if the cervix can be got in proper position. Where there is difficulty, eucaine anesthesia may be used to advantage. Many uteri that seem to have large cervical canals do not drain well, and a proper-sized Outerbridge tube, made preferably of silver wire, will make drainage efficient. Curage and intrauterine douching may be advisable where there is abundant or offensive discharge, and these measures are necessary when the uterus contains placental tissue, clots, or other débris. Local anesthesia will usually be sufficient for this purpose. Vaginal douches, hot as can be borne, continued for fifteen or twenty minutes, are very effective in relieving pain and promoting resolution, and if one-half per cent of carbolic acid be added they are more effective. These douches may be followed by tampons of glycerin and iodine and adrenal extract. Adrenal extract is the most powerful vasomotor and heart stimulant known, and is readily absorbed by mucous membranes. It is doing much for the ophthalmologist, and is, I believe, from my

limited experience with it, destined to be of great help to the gynecologist. Local applications to the lower abdomen are also useful. Hot turpentine stupes aid considerably in relieving pain, and may be followed by painting with iodine.

I believe that everything should be done that may be of benefit, however small, and that these various measures are not usually practised in a careful and systematic manner. Some physicians use one part of the treatment, others another; but it is only by combining all that the best results are to be obtained. This systematic treatment will result in a cure in the great majority of cases, and will reduce the inflammation in the remainder to a chronic stage.

I have taken much time with these details, because I wished to bring to mind the many useful means we have at command. I might speak for hours on the proper and improper ways of using these various means, for as much depends upon the minute details of technique as upon the remedy used; and I believe that gynecologists, in degenerating into pelvic surgeons, have forgotten these details to a great extent in learning the equally important details of surgical technique.

I will speak more briefly of chronic parametritis, but I must insist that surgery is not the only hope for chronic salpingitis, ovaritis, metritis, endometritis, and other conditions included in this term. I have had many such cases sent me for operation that I have cured without operation, and I would urge surgeons to give gynecology a fair trial in all cases, not really urgent, before operating. The cause may often be discovered and removed, and Nature will do the rest. Flexions and stenosis will be found a very common cause and one usually removable.

Two striking articles have recently appeared, one by E. Kehrer[1] and one by A. Müller,[2] in which a new light is thrown upon parametritis posterior. Both these papers are compiled from careful examinations of large numbers of cases, and show that most cases of posterior parametritis, not gonorrheal, are of intestinal origin; that they begin in catarrhal conditions and ulcerations in the lower bowel; and that removal of the uterine appendages is useless as a treatment. We have long known that constipation and other gastro-intestinal diseases are closely associated with uterine complaints, and in my early days I found it impossible to cure some uterine catarrhs that were

[1]Centralblatt für Gynäkologie, 1901, No. 52.
[2]Ibid., 1902, No. 52.

associated with gastro-intestinal catarrh; but it has apparently remained for these gentlemen to put a proper interpretation upon these facts.

Curetting does these cases no good, and removal of tubes and ovaries sometimes only aggravates their condition. I have seen some of these women cured, or at least greatly improved, by the stomach specialist. But there are cases of chronic salpingitis and parametritis that are curable only by pelvic surgery; and when other means fail after careful trial, I think they should by all means have the proper operation. I only ask that it be not done without due consideration and after failure of other treatment.

Some cases of congenital malformation or lack of development from their very nature are remediable only by plastic operation; and others, such as chlorosis and infantile uteri, are as plainly medical cases. But the most common cases are flexions, and these are best treated by gradual dilatation and the wearing of drainage tubes.

Such dislocations as procidentia or prolapse of the uterus or bladder frequently require operation for their cure, but I believe that anteversions and retroversions can usually be remedied by curing the endometritis that usually accompanies them, and by the use of tampons and the gradual breaking or stretching of adhesions with the finger.

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