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THE RELATION OF GYNECOLOGICAL SURGERY TO BAD OBSTETRICS.*

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PARTURITION is perhaps more difficult in the human race than in any other species in the mammalian kingdom, and in consequence much of the subsequent health of women depends on the care which they receive during the process of generation. Thirty years ago it was not an uncommon thing to see women die from mere exhaustion in unrelieved labor; a considerable percentage of all women died from the obstetric infections, and a larger percentage were left invalids after exhaustions which were not severe enough to kill. Thirty years ago almost all women who had borne children suffered from the result of unrepaired tears and the other mechanical injuries of labor. The grandmothers of that day were almost all elderly women, of whom little capacity for active exertion was expected. Even in the better-cared-for classes they stayed at home the greater part of their time, and when they went out drove because they could not walk. To-day the grandmothers of the better-cared-for classes are mostly young women, who walk freely, play golf and tennis, and are active in all the walks of life. This change may, I think, fairly be charged to a corresponding improvement in the practice of obstetrics.

To-day the obstetrics of the better-cared-for classes is pretty good. Most women among them escape any very severe degree of the evil results of parturition, and those who find themselves in any degree the worse for labor tend to seek early repair from the gynecologist. We do not to-day see among the better-cared-for classes those inactive old women who were the rule when we were children. In lesser degree the same improvement is to be observed in all classes in the community; and an increase of this improvement is, I take it, one of the objects of this meeting.

Obstetrics has improved in all ways. The bad obstetrics of to-day is seldom bad enough to cause death, but its faults are the old faults; and the exhaustion of comparatively unrelieved labor, the

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minor septic infections, and the mechanical injuries which so often result from labor still contribute their large quota to the gynecologist's practice.

Nothing in the neurasthenias which so often follow the exhaustion of neglected pregnancy and labor is more difficult than the decision to what extent their symptoms are to be attributed to actual local damage, or how much to weakened general condition and lessened power of resistance. Strong, well, and powerful women who have been in good condition through pregnancy need but little care in labor other than the avoidance of infection and the minimization of tears. Even delicate women usually go through carefully attended pregnancies and expedited labors, without permanent loss of health. The degree of the disturbances of pregnancy and the amount of labor which can be endured without injurious exhaustion varies with the strength of the individual woman, but all women who reach term exhausted and in bad condition tend to have lingering labors; and if their labors are likewise neglected and allowed to become unduly exhausting, they almost inevitably go through long periods of invalidism or depressed health, even though they may seem to escape the direct local lesions which bring them within the domain of gynecologic surgery as such. Such women are, however, usually improved by a subsequent well-conducted parturition; indeed, nothing in my experience as an obstetrician was more striking than that when such women subsequently became pregnant, were cared for accurately throughout pregnancy, and stimulated and hurried through labor, they usually not only escaped the neurasthenia which had followed former labors, but as a rule started off upon a new phase of greatly improved health. I believe, however, that this fact, which I saw too often to doubt its existence, is probably to be explained on the basis that this apparently purely constitutional ill health is in reality the result of unsatisfactory local conditions; that women in whom the processes of pregnancy and parturition have resulted in utter exhaustion are not able to conduct the processes of restoration of the genital organs to the normal in an efficient manner; and that their continued ill health or neurasthenia is thus in some degree the product of abnormal local conditions, though without definite and grossly recognizable lesions. No other explanation seems to me adequate to account for the improvement in general condition which so generally follows a subsequent well-conducted childbirth. There can certainly be no doubt but that general poor condition adds to both the severity and permanence of the evil effects of local lesions.

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Lack of time and space must prevent repeated references to this subject here, but it should be understood, nevertheless, as deserving emphasis in every section and at every stage of what remains to be said.

The modern gynecologist believes that a very large proportion of the cases which he is called upon to treat are the results of past infections, many chronic inflammatory states which were formerly attributed to other causes being now recognized as secondary results of preexistent infections.

Infective lesions of obstetric origin may be localized almost anywhere in the genitals, as, for instance, in the mucous membranes as an endometritis, or in the walls of the uterus as a metritis simulating subinvolution, but they usually in the end invade the Fallopian tubes and are most important and obstinate in that situation. We have only recently realized that many of the chronic tubes which we see as gynecologists originate in obstetric infections which are so slight as to be frequently unrecognized as infections at the time of their occurrence. These lesser grades of infection may in fact be so mild as to show little evidence of their existence during their acute stage, other than a moderate elevation of temperature with perhaps a little temporary pain or tenderness on one side or the other of the abdomen; and may yet be capable of originating a long-continued, low-grade inflammation, which eventually results in a ruined tube, chronic ill health, a resort to the gynecologist, and not improbably an abdominal operation. Such infections appear of little consequence at the time, but are sometimes far from trifling in their importance to the patient. If the obstetrician is so far a gynecologist as to be practically familiar with these remote results, the mildness of the initial symptoms is not likely to lead him into a false security. If he is also an expert in pelvic examinations, from the gynecological standpoint, he should be able to make a diagnosis of the existence of an infection in even the extremely mild cases; and he can then do an immense amount to prevent them from ending in chronic inflammation and disastrous remote results. An obstetric attendant who is not in practical touch with gynecological work is, however, too apt to consider these attacks unimportant, and to explain them in ways which are more agreeable to his pride, rather than to admit the presence of an infection. If he is inexperienced in gynecological work he is moreover apt to fail to diagnose them even if he is conscientious enough to try. The acute attack then passes off, and no attention is paid to its consequences during the remainder of the convalescence. In the majority of cases the affair

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receives no further attention until the patient turns up in some gynecologist's office after the lapse of months, or often several years a typical history, such as she then gives is that she has not felt really well since her last labor, that her monthly periods have been uncomfortable, and that she has from time to time been conscious of transient attacks of abdominal pain and tenderness. She has become nervous and irritable and in general unfitted for the duties of life. All these symptoms have gradually increased, and they are now becoming seriously important. Upon examination one or both tubes are enlarged and inflamed, and this condition is an adequate explanation for all the symptoms of which she complains.

There can be no question that such a case so presented is the result of bad obstetrics, but the histories are not always so distinctive. There are many doubtful cases, the relatively great importance of the lesser obstetric infections as a source of chronic disease has only recently become clear, and many persons are still too often misled by a theory which was for a long time widely accepted, and which still has so wide a popular acceptance that it is important to refer to it here.

It was formerly the custom to refer all doubtful cases to a hypothetical gonorrheal origin, but this superstition is much less prevalent than it was. The dramatic and striking theory that a man who had once been the subject of a gonorrhea and has been apparently cured for years, nevertheless habitually remains for long periods capable of infecting the innocent girl whom he subsequently marries, was set forth some twenty odd years ago on quite high authority in so specious and persuasive a manner as to obtain general acceptance from the profession, partly no doubt from the catchy title of "Marital Gonorrhea" which was attached to it. From the profession the theory of the enormous prevalence of "marital gonorrhea" spread generally to sociologists and to the thinking public in general, and has worked a great amount of harm. Now that the profession is recovering from its hysteria on this subject it is time that more correct views should be urged upon such gatherings as this.

It must not be understood that "marital gonorrhea" is wholly a myth; there is no question but that there are exceptional individuals who, though apparently cured of a gonorrhea and free from symptoms, nevertheless remain sources of contagion for prolonged periods, precisely as is now known to be the case with some individuals who have had typhoid fever; there is, however, absolutely

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no evidence that such a condition is in any sense common, and there is abundant evidence that it is of exceptional occurrence.

More careful study of case histories has moreover made it clear that a large proportion of the chronic salpingites which were formerly loosely considered gonorrhea are in point of fact obstetric in their origin, and a majority of the remainder are probably referable to a third source of origin, to which a few words may properly be given here. The skin of the vulva and perineum is always surgically unclean with colon bacillus and other intestinal bacteria. In the ordinary course of life these bacteria are mechanically introduced into the vaginæ of married women at frequent intervals, and chronic infection of the organs thereby is prevented only by a protective mechanism in the chemical and mechanical reactions of the secretions. These reactions are, however, delicate and easily thrown out of adjustment and a considerable proportion of the chronic infections probably originate in this sort of accidental contagion by non-specific bacteria.

It is unnecessary to go further into these side subjects, but some reference to these other forms of infection has seemed necessary to a presentation of the now undoubted fact that unrecognized minor obstetric infections are responsible for a great amount of the pelvic ill health of women.

These infections occur with great frequency in the community at large, and are not rare even among the women of the better-cared-for classes, or in the practice of well-trained physicians, yet even the minor infections have been well-nigh eliminated from surgery. The contrast is a marked one and at once raises the question, How far are we justified in blaming our obstetricians for this difference? At first sight the fault would seem to be theirs. A closer analysis will, however, refer it to an essential difference in the conditions under which the two kinds of work are done.

Infections will become as rare in obstetrics as they are to-day in surgery only when all labors are conducted in specially prepared rooms, and only by specially trained obstetricians, each of whom is moreover surrounded by a corps of assistants, trained to anticipate his every want and to render it practically impossible that his hands should at any time touch anything that has not been previously rendered aseptic. These are the conditions which are provided for surgical operations.

A proposal to surround all or indeed any of the labors of the community by such precautions is, however, at present a mere *reductio ad absurdam*. Except in the rarest of cases it is economically im-

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possible to furnish such attendance throughout the whole length of labor outside a hospital; and the relegation of all labors to hospitals is impractical in our present degree of civilization—even if a sufficient supply of such hospitals existed, which it does not. The women of the better classes will not, the wives of the poor cannot, leave their homes, and in many cases their children, for the sake of better attendance in labor. In point of fact, it is doubtful whether the amount of ill health of obstetric origin which exists to-day is as great an evil as would be involved in other economic ways by such a change of habit. The moderate frequency of the minor obstetric infections which obtains to-day among the well-to-do classes and in the hands of the best obstetricians is probably the highest degree of the prevention of infection which can reasonably be aimed at.

It is, however, within the power of such an Association as this to exert great influence toward the almost equally important object of the prompt recognition of all infections as such. Many of the minor infections are unquestionably recovered from without lasting ill effects. It is probable that if all of them were recognized as important, and subjected to early and sustained treatment, the proportion which prove harmless would be enormously increased. To-day the community believes that every infection is the fault of the obstetrician, and it is only among the most intelligent patients that any practitioner dares admit that any complication which occurs is the result of infection. Under these conditions but few physicians will be over-ready to diagnose or treat doubtful and mild seeming attacks as being important on account of the possibility that they are infections. When the community has been taught that the conditions under which labor is conducted render the occasional occurrence of the minor infections humanly speaking inevitable, then the first step toward their early recognition and prompt treatment will have been taken.

The mechanical misfortunes of labor which are of interest to the gynecologist are the tears and displacements, and the combinations of these lesions, especially if they are complicated by subinvolution. There are two common tears. Tears of the cervix tend to heal spontaneously if the labor was thoroughly aseptic. It is only in the presence of some degree of infection that they result in the slow healing and the formation of cicatricial tissue which in the end brings their victims to the gynecologist. Tears of the perineum remain open and heal over in this condition unless they are repaired by suture. This tear is of almost invariable occurrence, some degree of it being produced in practically every labor, and one of the greatest

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obstetric advances of modern times is that the recognition of this fact has led to its habitual primary repair. It was formerly believed that all tears were the fault of the obstetrician, and as an almost inevitable consequence of this injustice only the worst of them were admitted and sutured; the remainder of them went unrepaired. The community now know that some degree of tear is inevitable, the obstetrician never hesitates to look for them, and all but the most trifling are promptly repaired.

It is not, however, generally understood that primary repair is seldom completely satisfactory even in the most skilful hands. The community as a whole still believes that any imperfections in the results of primary repair are necessarily the fault of the obstetrician. As a consequence of this injustice few obstetricians examine the results of their repairs unless in the process of the removal of sutures, and few admit any imperfection in the results even when they are bad. In skilful hands primary repair yields in the great majority of all cases results which are of great value at first since they postpone trouble for many years, but which are often not sufficiently good to afford first-rate support after the muscles have been repeatedly overstretched in the course of subsequent labors, or after they have lost their resiliency in the process of the change of life. Every woman who has been torn should be examined after the lapse of some months from her delivery, and should then be honestly informed as to how good the results have been, and what she may probably expect from them in the long run. So soon as the community thoroughly understands that the permanence of the results of primary repair depends quite as much upon conditions which are beyond the control of the obstetrician as upon his personal skill, that variation is to be expected and provided for, so soon such examinations will become the rule; then cases in which the muscles are yielding and stretching will be cared for early and when minor means are sufficient, and an immense amount of ill health will thus be saved. The gynecologist can do the community no greater service than to spread broadcast among women the information that women who go into the change of life with their organs in good condition tend to pass through that process with little or no disturbance of health, and to be thereafter in better health than they have known before rather than in worse; on the other hand, those who enter upon the menopause with their pelvic organs in disturbed and damaged condition inevitably pass through a period of nervous ill health, which unfortunately then tends to persist in greater or less degree during a large part of the remainder of life. All women who have borne children

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should be looked over at the end of the child-bearing period in the early forties and any abnormalities then found should be corrected for the sake of their health during the remainder of life. Originally it was the office of the dentist to pull teeth, now it is his business to preserve them. Women approaching the menopause should consult the gynecologist in precisely the same spirit in which we have all learned to go to our dentist throughout life.

Displacements of the uterus of puerperal origin are practically always complicated by subinvolution of the uterus—that is, its failure to return to a normally small size or to a normally firm consistency as a result either of infection or of mismanagement of the convalescence. The prevention of subinvolution rests on the observance of that extreme asepsis which is perhaps the most important of all items in obstetric practice, and on that adequate care of the convalescence which has now to be spoken of from the gynecologist's point of view. All women desire to get up early both from the irksomeness of remaining in bed and also frequently as a matter of pride. Many physicians yield to this desire of the patient against their own judgment and for the sake of pleasing them. From time to time there have been well-known obstetricians who have advocated getting the patient up early, but it has usually been remarked that the patients of these men were very apt to become in excessive number the patients of other gynecologists in the vicinity, and I know of no opinion in favor of this practice now.

I have noticed with much interest that the wives of gynecologists, and, indeed, even the wives of obstetricians who are not gynecologists, always stay in bed at least three weeks. They often stay in bed longer, and they are always very restricted in their lives for from three to four weeks afterward. No trained expert whom I have seen under these circumstance has seemed to have any doubt but that *his* wife must pursue this regimen, no matter how well she feels, or whether she likes it or not. The stronger the muscular system of a given woman the more likelihood of her escaping the evil results of getting up too early after delivery, but it is not a desirable thing for the strongest woman, and the reasons for this become apparent when we consider the details of what the organs go through in the process of repair after childbirth. The uterus immediately after delivery weighs upward of 2 pounds and is very soft and flaccid, easily assuming any shape into which it is pressed. The non-pregnant uterus weighs but 2 or 3 ounces, and is normally so firm as to be susceptible of but slight change of shape. This great reduction of weight and change of consistency is not thoroughly

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completed under eight to twelve weeks, but proceeds so much more rapidly at first that by the end of three to four weeks the uterus is usually of not more than twice its normal weight. The involution of the uterus is, however, not the whole process. The supports by which it is held in place also elongate and soften during pregnancy as greatly as does the uterus itself. They are left after delivery long, loose, and flaccid like the uterus, and their involution occupies about the same time. If a woman who has not been delivered more than ten days or a fortnight is allowed to return to active life in the erect position with her uterus still many times heavier than normal, still soft and capable of almost any change of shape, and held in position only by supports which are still long, soft, and weak, arrest of involution and a high percentage of displacements is the necessary mechanical result. Properly long duration of stay in bed and the resumption of the recumbent position at frequent though decreasing intervals after the patient begins to get up helps involution and tends to prevent the occurrence of displacements.

One other point should be noted: displacements which have once been acquired are rarely permanently relieved without operation except by active treatment of them immediately after the termination of a subsequent pregnancy. If treatment is undertaken at that time the vast majority of them can be permanently cured by minor treatment. A uterus which has once been displaced always tends to resume its displaced position during the puerperium, and if the surrounding supports are allowed to return to their normal degree of contraction and firmness while the uterus is still displaced the woman has a return to her original condition of established displacement. If, on the other hand, the uterus is held at this time in normal position, until the supports have returned to normal contraction and firmness with the uterus in this position, the woman will start again with her uterus firmly held in normal position and with but little liability to the recurrence of a displacement. This fact is but little known in practice. It is, however, not theory but a process which I have observed again and again, and which I have but rarely known to fail.

Any woman who has been the subject of a displacement should should have treatment for the displacement undertaken at about the tenth day after delivery. The uterus should be placed in the position of anteversion and a very long, though if necessary narrow, pessary should be arranged to hold it there.[1] The vagina is of course

[1] Even if there has been a laceration of the perineum and primary repair it is usually possible by this time to introduce the necessary pessary without disturbing the stitches.

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at this time capacious and is in the process of involution, hence a pessary which is as large as is necessary at first will soon become too large, and it is necessary to reduce the size of the pessary at frequent intervals, at first as often as once a week; as involution progresses it is, however, slower, and the pessary will need less frequent changes. If the uterus is held in anteversion until the end of the first six or eight weeks and in normal position for a couple of weeks thereafter there will be but few cases of recurrence of the displacement, and this is about the only time in a woman's life when an established displacement can be permanently cured by the use of a pessary.

Thirty years ago the death rate of obstetrics was enormous—until that was reduced its morbidity was a comparative unimportant matter. To-day the death rate of obstetrics is low, and so far as we can at present see, as low as it is likely to become, but the amount of ill health from obstetric causes through out the community is still large, and most of it is preventable and unnecessary. The improvement in this respect which must be aimed for, and should be attained, is rendered difficult by the fact that these evil results for the most part appear along after the confinement, and even though they may be directly due to it, are too often unconnected with it in the mind of the physician. To this evil the system of teaching these subjects and of specialization in them which is somewhat widely prevalent in America largely contributes.

Everywhere else in the world obstetrics and gynecology are regarded as one subject, are so taught to students, and to a great extent are practised by the same men.

Many communities in America are served by gynecologists who have never known anything about obstetrics, and by obstetricians who know nothing of gynecology. In these communities students are consequently taught their gynecology by men who know nothing of the obstetric origin which underlies so much of it, and are taught obstetrics by men who rarely see a case after the woman is up and about from childbirth. Can we expect that men who are the products of such teaching will conduct the labors of their patients with much regard for the happiness or health of their after-lives?

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