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Editorial

DIAGNOSTIC CURETTAGE*

BECAUSE of the present tendency, in some quarters, to advocate vaginal hysterectomy in all cases of indefinite uterine bleeding, regardless of diagnostic curettage, and as April is the cancer month in the United States, it seems to me the consideration of the subject is very timely; moreover it is of general interest.

In 1914, I read a paper before the Obstetric Section of the New York Academy of Medicine entitled "Complete Removal of Adenocarcinoma of the Uterus by Exploratory Curettage" and described three personal cases. The fact that early adenocarcinoma can be removed completely by curettage is of no extraordinary significance; but because the cases were the first to be recorded in all of the American and British literature, I was prompted out of a pioneering spirit and professional vanity to report them. However, eighteen cases were reported in Germany and Austria between the years 1888 and 1913. After the publication of my paper in 1915, similar cases were recorded in the United States and in nearly all civilized countries.

These cases were not offered by me as examples of cure of corporeal carcinoma by curettage, as was misinterpreted by some writers. On the contrary, immediate total extirpation of the uterus was definitely urged in all cases in which microscopy of the curettings showed malignancy, including the cases in which a second curettage was done for some reason or other and showed that the lesion had been entirely removed by the first curettage.

However, while I was preparing the paper it occurred to me that it would be a great boon to womankind if carcinoma of the body of the uterus could be detected in its incipiency, and that in diagnostic curettage we had the readily available means of doing it. The paper was accordingly devoted to an earnest and urgent appeal for the general adoption of diagnostic curettage as a routine measure in all cases of doubtful uterine bleeding; and this applies especially to women approaching the menopause and to those beyond it.

Here I would like to sound a word of warning: It must not be taken for granted that the uterine bleeding in menopausal cases is due to the administration of estogens without confirmation by a diagnostic curettage.

I confess that this appeal did meet with some opposition then. Among some of the objections was the possibility of stirring up something by the curette. This is not in accord with my experience. I have never met any untoward effect from an intelligent use of the curette, and it has been my

* Read at a meeting of The Clinical Society of the New York Polyclinic Medical School and Hospital, May 1, 1944.

practice for many years to perform a preliminary curettage to all hysterectomies in which there is the slightest doubt as to the benign condition. If the curettings appear negative on gross inspection, a supravaginal hysterectomy is performed immediately; but if the gross inspection of them is positive or on the border line, the indicated total hysterectomy is postponed until the diagnosis is confirmed by the microscope. There is a twofold reason for this procedure: First to determine in advance between the choice of supravaginal and total hysterectomy, because the difference between them in my opinion is that between a minor and major operation; and the other reason is to avoid a most disagreeable surprise and embarrassment both to the surgeon and relatives on discovering malignancy in the uterus after it had been extirpated.

Another and most conclusive answer to the above objection can be found in the fact that in some of the cases reported here and abroad, the uterus was not extirpated because a second curettage showed the lesion had been completely removed by the first curettage and the patients remained well for some time.

"A Plea for Early Diagnostic Curettage and Routine Microscopy of Curettings for the Detection of Adenocarcinoma of the Uterus" was the title of a paper I read at a symposium on cancer before the New York County Medical Society in 1927. This paper was published in February 1928, and, I believe, met with general favor. This belief was strengthened when The American Health Association invited me to give a talk on "What Women Should Know About Cancer," over Radio Station WJZ, June 5, 1929, and I dwelt particularly on the advantages and benefits of a diagnostic curettage.

Diagnostic curettage still is and will remain the most reliable and effective means available of detecting adenocarcinoma, especially in its earliest stages and, in my opinion, will never be replaced by the hit or miss, mostly miss, expedient of a prophylactic vaginal hysterectomy, which in many instances, will add to the list of operations unnecessarily performed.

Curettage for diagnostic purposes is of no value unless it is performed with particular care and special attention is given to the shape of the uterine cavity. The uterine cavity is not tubular but triangular, flattened before backward, with its walls closely approximated and joined at sharp angles on either side. At each superior angle is a funnel-shaped cavity at the bottom of which is the orifice of the Fallopian tubes, and unless the curette covers the entire surface of the cavity in a systematic and thorough manner, an early lesion may be overlooked. However, as the curettage is done primarily for diagnostic purposes and not as a curative measure, it should be discontinued in the later stages of the disease, as soon as sufficient material is procured for microscopic examination.

It is needless to say that the microscopy must be done by competent pathologists. While frozen sections may be relied on in tests for cancer in other parts of the body, it must never be used in the examination of uterine curettings; and here I desire to stress the fact that only paraffin sections of all material removed by the currette should invariably be used for microscopic examination.

I will cite a case showing the importance and value of the procedure and also of the above precautions: Some time ago a doctor referred a patient to me whose history and findings were suspicious of malignancy. I advised a diagnostic curettage which I performed at the Polyclinic Hospital. The doctor, because of his anxiety to learn the result had a frozen section examined against my advice, which proved to be negative and he so informed the patient. She thereupon decided to leave the hospital. With some difficulty I persuaded her to stay until paraffin sections could be examined which proved positive for adenocarcinoma. I performed a total hysterectomy and she has been well since.

The laboratory report follows: "The microscopic examination of the curettings showed adenocarcinoma of the uterus, which is probably not invasive, and should the uterus be removed may be found for the most part to have been curetted away. On gross inspection there is found a small cellular area in one corner of the uterus which is apparently a focus of adenocarcinoma. This on microscopic examination showed adenocarcinomatous growth corresponding to that found in the curettings removed previously." The slides were sent to Dr. Ewing for confirmation and I quote from his report: "In the section of uterus of X I do not find any tendency to infiltration of the muscularis by the adenocarcinoma and on that account I do not think postoperative *x*-ray treatment is indicated."

This case, one of a number of similar cases, is especially interesting as an illuminating example of the great value of diagnostic curettage and the importance of the precepts stressed above. If this patient had left the hospital without submitting to a hysterectomy and would have decided on another curettage by another surgeon or even by me before undergoing operation, in all probability, because of the location of the lesion, no trace of malignancy would have been found in the second curettage, and the proper treatment might not have been instituted. This actually happened in one of the three cases I reported in my first paper.

There is no room in this country for an advanced case of adenocarcinoma of the body of the uterus. Every such case records an instance of neglect on the part of the patient, a wrong diagnosis or a diagnosis made too late, and presents an example of a woman suffering from cancer who has been denied the benefits and the advantages of early diagnosis and the hope of cure that early treatment affords. I very much regret to say there is still room for the necessity of reminding the public and the profession that diagnostic curettage is absolutely and positively a life saving procedure.

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