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ADDRESS IN GYNÆCOLOGY

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Mistakes in Diagnosis and Treatment

FROM the standpoint of a consultant of over thirty years' standing, I have learned something of the mistakes in diagnosis and treatment made by myself and others. I have conceived the idea that some consideration of this subject might not be unprofitable before a meeting mainly of general practitioners.

It is a trite saying, that we learn more from our failures than our successes. It is, perhaps, equally true that we learn more from our mistaken than our correct diagnosis. The lessons we thus learn are often painful and the experience bitter, but they are not likely to be forgotten.

Accuracy in the diagnosis of pelvic conditions depends mainly on education of the sense of touch. This can only be obtained by long and patient practice and many opportunities for making examinations. All teachers of practical gynæcology will bear me out when I speak of the difficulty in giving to the medical student more than a few opportunities on the patient. It is far other with the teacher of clinical medicine, who can, in most cases, allow an unlimited number of students to examine a chest or lung case.

Nevertheless, many fewer mistakes would be made if attention were given to a few simple details. In this, as in everything else in medicine, the grand safeguard against mistakes are system and method in case-taking and examination. As a rule, a woman's pelvic organs cannot be satisfactorily examined if she lie on a bed or couch. The many advantages of a table, a firm surface, for the physician's comfort, have only to be experienced to be realized. I am well aware of the difficulty in getting many women to consent to this, especially if the practitioner be young. Suitable personality and tactful manners will, in most cases, lead to success.

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The condition of the adjacent viscera, the bladder, and rectum, is all important. The rectum must have been emptied before the patient comes to the examining table. With reference to the bladder, my own practice, learnt by personal experience, is to empty the bladder by catheter after the patient is in position on the table. The advantages are that: (1) We may note the presence or absence of discharges, such as that of gonorrhœa, about the genitals, and their character, a very important kind of evidence which we should lose if we allowed the patient to pass water naturally. (2) There are many women who when asked to pass water immediately before a pelvic examination are unable from nervousness to do so. (3) We get an uncontaminated specimen of urine for examination.

When, from a suitable position of the patient, whereby the abdominal muscles are thoroughly relaxed, we may still have to contend with rigidity from nervousness or ticklishness on the part of the patient, this may be overcome by a manœuvre which I frequently practice with success. It consists in making a series of circular, frictional movements over the lower abdomen. These should first be in a circle of relatively wide diameter, the whole abdomen, but gradually narrowed to one much smaller. What do we gain by this manœuvre? If gently executed we overcome rigidity of the abdominal muscles and we displace gradually the intestines. These movements are the first thing done in the practice of the Thure-Brandt method of pelvic massage.

Medical students and doctors of little experience have often complained to me of being unable to reach the structures at the upper and back part of the pelvis because their fingers were too short. The relatively long posterior vaginal wall can be, in a sense, shortened by steady, gentle, continuous pressure on the perineum, whereby it is partially turned into the vagina.

In physical examination for pelvic diagnosis I would strongly urge caution in the use of the sound. Apart from the danger of inducing abortion in unsuspected pregnancy, unless strict asepsis be practised, the sound is a dangerous instrument. Many a woman has died of the uterine sound. In the great majority of cases it cannot be used without abrasion of some part of the uterine canal. Unless instrument, hands, and field of operation be sterile, there is great danger of infection, and this has often been the consequence, setting up more or less serious, and sometimes fatal, pelvic inflammation.

With all due respect to the great Sir James Simpson and others whose names are so intimately connected with the use

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of the sound, I am convinced that it is a much overrated instrument. In hands skilled in bimanual palpation it is rarely necessary, while in hands unskilled, it will hardly ever add to useful, practical understanding of the case. As a consultant I have learnt that the sound is a great deal too much used by the general practitioner.

Mistakes in the diagnosis of retroversion of the uterus, either way, that is to say, mistaking retroversion for other conditions or mistaking other conditions for retroversion, are certainly amongst the commonest. But, indeed, accurate diagnosis in complicated conditions (and complicated conditions are common and the most important), is often most difficult. A common mistake is overestimating the importance of retroversion, of the displacement *per se*, in a complicated case, as of pelvic inflammation directly inducing the displacement. Such an imperfect or mistaken diagnosis may lead to an attempt to replace the uterus by sound or repositor, and to its mechanical treatment by pessary, with, most probably, disastrous results.

This leads me to speak of mistakes in overestimating the importance of deviation of the uterine axis from the normal. No more fierce, wordy wars have ever been fought than by gynæcologists over the relative importance and order of occurrence of displacements, and those changes in the circulation and nutrition of the uterus to which we apply the term chronic metritis. The *Transactions of the Obstetrical Society of London* of about forty years ago teem with the discussions. While most of us claim to have obtained a position nearer the truth, the consultant still finds in the body of the profession imperfect views and inadequate conceptions of the subject. It seems often to be forgotten that the uterus in health is essentially a very movable organ. It is pushed backwards by a distended bladder, forwards and upwards by a distended rectum, and by every act of respiration, especially by forced respiration, as in coughing, vomiting, or violent effort, it is deviated from what may be considered the normal, and all such displacements, temporary it is true, are attended with relatively little in the way of symptoms attributable to the uterus.

I am next led to speak of another mistake which we have made in the past, but which we are, most of us at least, now rectifying, and that is in failing to recognize that in many women a displaced uterus is only one element, though certainly a very important one, in a case of more or less general descent or sagging of abdominal viscera, the condition of enteroptosis. For many years I have,

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in every case I examine, made a point of examining for the position of the kidneys as well as other viscera of the abdomen. Displacements of these organs in gynæcological cases are of extreme frequency. It is true that descent of the kidneys does not always cause symptoms. In exceptional cases the symptoms are grievous. In the parous woman they are especially so. The commonest and perhaps the most important mistake here is in overestimating the importance of the pelvic condition and neglecting to take into account the rest. The repair of a lacerated perinæum, the necessary colporraphies, and the performance of a selection from the various forms of fixation or suspension of the uterus, may for these reasons be disappointing in their results.

In the management of displacements by many practitioners, mistakes are often made in overestimating the usefulness of pessaries, in the selection of cases suitable for their employment, in the selection of a pessary for a particular case, and in the neglect of the very frequently necessary preliminary treatment of the patient and the parts against which the pessary will lie. Ofttimes, too, there is lacking an adequate conception of the necessary care of a patient who is wearing such an appliance. The consequence is that appliances, which in suitable selected cases are undoubtedly most useful, suffer undue and unmerited discredit.

The sensations of the patient which suggest to her mind displacements of the uterus, and which are apt to be accepted by the inexperienced physician, are often due solely to vaginitis. This condition, when of the fundus of the canal, where it is often mainly or exclusively present, can only with ease or certainty be diagnosed and treated by the Sim's method of examination. This method of examination, it would appear, is learnt by only a small number of those who practise gynæcology. It requires the patient to lie on a table in the necessary position, to have her clothing loose, and to breathe quietly and naturally. All these conditions being fulfilled, the use of the Sim's speculum is merely an accessory, for the bent handle of a pewter spoon or even the finger will sometimes suffice to retract the perinæum and posterior vaginal wall and expose the now distended vagina, the result of atmospheric pressure acting under altered relations of abdominal and pelvic organs. A careful examination by this method (which, I contend, should be practised in every case with pelvic symptoms) will often lead to the discovery of a degree of vaginitis which can be most satisfactorily relieved by a few applications of silver nitrate solution.

Perhaps no more common mistakes are made than in the

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diagnosis of pregnancy, and all will bear me out when I attempt to emphasize their importance. Of the effect of such mistakes on the reputation of the practitioner, I feel sure that some at least here present are prepared to bear me out. Failure in the recognition of existing pregnancy is rarely pardoned by a woman. Failure to discover that she is performing the supreme function of her sex, and to give her credit for it, is to her a grievous fault. Apart from this, there is the obvious importance of early knowledge of the fact in order that plans may be made and necessary arrangements put in train. The cases are few in which a diagnosis cannot be made by a careful investigation of history, symptoms, and physical signs, negative and positive. I must, however, not forget to admit that we are not always freely admitted to possession of each of these sources of evidence. Many women are proverbially inaccurate as to dates and in the description of symptoms, and we must ever be on our guard against the designing woman, legitimately or illegitimately pregnant, who wishes to rid herself of the product of conception, and who hopes that by the use of the sound or other instrument incautiously used by the practitioner, her purpose may be effected. While history, symptoms, and the condition of the breasts are all important, the supreme value in the estimation of the various sources of evidence is to be placed on the bimanual palpation of the uterus. I am in the habit of impressing this on my students. If, with empty bladder and rectum, and everything else favourable in the position of the patient, you cannot easily define the uterine body, so distinctly firm in the nulliparous condition, then suspect pregnancy. It is thus soft in the condition of pregnancy, and comes nearly to the feel of the roof of the vagina and other structures in the pelvis. If the uterus can be defined, the value of the so-called Hegar's sign—the sudden increase of size above the junction of the body and the cervix—is very great. It is in early pregnancy that mistakes in diagnosis are most frequently made, but I have known not a few in the more advanced stages. Cases are not unknown of all the arrangements having been made for operation for ovariotomy, and the patient, meanwhile, being delivered of a full-term child. This has occurred to men of world-wide reputation, the authors of books, and numerous papers on obstetrical and gynæcological subjects. In one instance, which occurred to me, ovarian cyst had been diagnosed, and the woman being in great distress from the enormous distension, she had been twice tapped. She travelled over five hundred miles to reach me for operation, all the preliminaries having been arranged.

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I found her resting on her hands and knees in my waiting-room and in that position she had remained during the night in the sleeping car. On examination, I was immediately able, through the cervix, to recognize fœtal parts. The case proved to be one of twin pregnancy with hydramnios. The gravid uterus had been tapped, and the liquor amnii drawn off. Beyond a doubt, the true nature of this case would have been recognized by a careful consideration of history, symptoms, and physical signs, instead of by the mental attitude of taking certain things for granted. Recorded instances are by no means single of operators, when doing hysterectomy for fibroid, being surprised by the discovery of early pregnancy. It is safe to say, from what we know of the very human nature of our profession, that many more have never been recorded. The sudden increased activity of growth of fibroids previously unsuspected, in the gravid condition of the uterus, certainly, in many such instances, must have led to the experiences just alluded to. I venture to make the assertion that they are very rarely unavoidable.

So much for the diagnosis of uterine pregnancy, undoubtedly often beset with difficulties. The cases are rare in which there is a necessity for immediate action. In all cases of doubt or difficulty, the doubts should be frankly stated, and time and further opportunities for examination requested. The cases are few in which the practitioner will not by such a course retain the confidence of the patient and her friends, whereas a positively given mistaken opinion will, in most cases, be disastrous to his reputation.

If the diagnosis of uterine pregnancy be difficult in certain cases, it is vastly more so in the case of extra-uterine pregnancy, whether early or advanced. I venture the assertion that there is no operator of large experience in pelvic surgery who has not at some time or other operated for tubal pregnancy and found something else; or has operated expecting something else and found ectopic gestation. I have to confess having made such mistakes more than once. There are many deviations from what may be called the symptom-complex of this grave condition. In the early stage of extra-uterine pregnancy the conditions most apt to be confounded with it are the various inflammatory conditions of the uterine appendages, cystic adherent ovaries, hydrosalpinx, appendicitis, etc. In the rarer instances of rupture of the gravid tube with speedy fatal hæmorrhage (and the danger of this is much greater when the gestation is in the relatively indistensible and more vascular part of the tube, near to the uterine end), the symptoms

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have in several instances given rise to the suspicion of death from poisoning or by violence.

This suspicion was very strongly entertained by the friends of a patient whose case was reported many years ago to the Montreal Medico-Chirurgical Society. This woman, who some time previously had been a patient of mine for office local treatment, ceased to attend, and the next thing I heard of her was that she had died seven hours after having been seized with violent abdominal pain and other symptoms. The nearest doctor had been called, and, failing to recognize the real nature of the case, he had administered morphine. The death of the patient was attributed by the friends of the patient to the drug. An autopsy was demanded by the doctor, and at first refused, but when threatened with a coroner's inquest they finally consented. The belly was found full of liquid and clotted blood which had come from the rupture of an expansion of the tube no larger than a shelled almond, situated one inch from the horn of the uterus. Even in this case a careful enquiry into the history and symptoms preceding the attack might have suggested the true nature of the case, for the woman had had pelvic symptoms which had been relieved by treatment, after which she had become pregnant. As Gaillard Thomas pointed out in a paper written by him many years ago, in the majority of the cases of extra-uterine pregnancy reported, the patient is pregnant for the first time, or for the first time after years of sterility, during which she has suffered from pelvic symptoms, and from which she has partially or completely recovered, spontaneously or while under treatment. My own experience amply bears out these observations of Thomas and others.

The correct diagnosis of uterine fibroids, while usually easy, is sometimes most difficult, and the history of the subject is fraught with mistakes. I have more than once opened the abdomen for operation to remove a uterine fibroid to find that I had to deal with the much simpler condition of intra-ligamentous cyst. So tensely filled are these cysts sometimes and in their process of growth so close do they lie to the uterus, that by position and consistence they now and then closely simulate the common, solid tumour of the uterus. The diagnosis of uterine fibromyoma from intrapelvic cancer, usually ovarian, in its early stages, is by no means always easy. One mistake of this kind occurring a good many years ago mortified me very much. The physical signs were such that my diagnosis was multiple fibroids. In a few weeks failure of flesh and strength and the appearance of peritoneal fluid aroused

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suspicions of malignant disease, which were confirmed by exploratory operation.

All ovariotomists and abdominal surgeons of much experience have been disappointed and saddened by the appearance of intrapelvic and abdominal cancer within a year or two after a smooth recovery from the operation of removal of an ovarian tumour, apparently quite innocent in its character. Lawson Tait used to remark something to the effect that every ovarian tumour had in it the elements of malignancy. His remark was doubtless the outcome of the experience I have alluded to. It would be more correct to say that if the whole of every ovarian tumour were submitted to careful microscopic examination by a competent pathologist, many which appear benign would show malignant characters. This fact is a strong argument, if any were needed at the present day, for the prompt removal of every ovarian tumour as soon as possible after its discovery. In malignant tumour of no other organ is radical cure by operation so hopeful.

Nothing in the experience of the gynæcologist is so saddening as that of cancer of the uterus. In the vast majority of the cases when first seen the only verdict to be rendered to the anxious patient is "too late" to do anything but make the last months of life as little miserable as possible. In by far the larger number, the woman does not seek advice from her ordinary medical attendant until her case is hopeless for radical cure. In too many instances, even when opportunity for examination has been given, the true nature of the case is not suspected. In my experience the worst case of this kind was that of a woman who was sent to me by her medical attendant in the hope that I might be able to cure a vesico-vaginal fistula, the result of cancer of the cervix that had extended to and perforated the vesico-vaginal septum. This neglect of uterine cancer is due more than anything else to the delusions so universal in the popular mind concerning so-called change of life, delusions which I regret to say are shared by a small, though I am pleased to say diminishing, section of the general profession. Such are the prevalent ideas, that at the age of from forty to fifty women are subject to profuse and irregular discharges of blood, and that the essential symptoms of cancer are pelvic pain and fœtid leucorrhœa. The experienced gynæcologist knows that, save in a few exceptions, menopause is not attended with menorrhagia or metrorrhagia, except when some form of organic disease exists, and that such symptoms demand prompt pelvic examination. If this be true of women who have not yet attained menopause, it

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is vastly more true of those who have ceased to have discharges of any kind for months, or years, and yet I have known a number of instances of women of fifty and over, one of sixty-five, in which the appearance of a bloody discharge was welcomed, and announced with pride to her friends by the woman as a return of the distinctive characteristic of womanhood—as a renewal of youth. One woman said to her friends, "I am getting young again." In my experience the appearance of bloody discharge in a woman who has ceased to menstruate means malignant disease and nothing else in ninety-five per cent. of the cases. In the other five per cent. the source of the blood is that interesting form of vaginitis which the late Professor Hildebrandt, of Konigsberg, proposed to call "vaginitis adhesiva ulcerosa." As regards the significance of pain and fœtid discharge, I wish to say with all the authority I may command as a consultant, that while invariably present in the advanced stages, they are almost as invariably absent in the early and manageable stages, and yet it has many times been replied to me when I had announced my diagnosis, "why the woman has had no pain or ill-smelling discharge."

If there is one early symptom of cancer more suggestive, even significant I ought to say, of the early stage of cancer of the uterus, cervix or body, it is the appearance of a thin, serous, slightly turbid, sometimes pinkish at first, and for many weeks usually inodorous, discharge. This so-called "meat-water" discharge at any age ought at once to arouse suspicion in the mind of the practitioner consulted, and lead him to insist on an examination with all the authority he can command. The reason should be given if necessary, and if he is refused he should wash his hands promptly of all responsibility in the case.

Malignant disease of the body of the uterus is undoubtedly very rare as compared with similar disease of the cervix, but I have found that its frequency and the possibility of it are much under-estimated by many practitioners. The symptoms in a given case have led to the suspicion of malignant disease, the patient has been examined, the cervix has been found smooth and healthy, and the uterine body normal in size and symmetrical. Then, too often, has it been concluded that there is no cause for alarm, and the fatal malady, which could only have been revealed by the dilator and curette, is allowed for a time to go on with its stealthy pace till other more prominent symptoms arise.

And now I come to another class of mistakes, very common, much less serious in their results it may be, but certainly of great

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importance from the point of view of their effects on the patient's prospects and the practitioner's reputation. I allude to an underestimate on the one hand and overestimate, more frequent perhaps, on the other hand, of the influence of disease and derangement of woman's sexual system on her symptoms and health generally. While it is true that there is scarcely an organ or function of the body which may not be disturbed reflexly or sympathetically by disease, or disturbances of function, and in many instances, even by the physiological performance of function of woman's sexual system, yet it is most necessary that in every individual case the symptoms should be studied in the light of heredity, early training, and any other influences which may have determined the type of nervous system. And for the rest, in studying a gynæcological case, the same methods should be pursued as those by which every case of disease is or should be studied, every organ and function carefully interrogated. In this way only may be avoided such grievous mistakes as removing healthy ovaries for painful menstruation, when that disorder is merely a local expression of a morbidly sensitive nervous system, inherited, or, as it may be, in many cases, acquired.

I feel that I must not conclude my discussion of this subject without an allusion to a class of mistakes which concern and influence the sexual hygiene of woman. Such are the mistakes of omission of the family doctor who fails to urge the mothers or guardians of young girls to inform those under their charge of the important matters pertaining to sexual hygiene. No girl can know by intuition the significance and importance to her health of a normal performance of the function of menstruation. How many instances have we not known of fright from the appearance of the discharge, of the use of cold water to remove it as an unclean thing, or its disregard or of its deliberate arrest, so that the pursuit of pleasure might not be interfered with. Such is undoubtedly often the result of ignorance, though many times also from wilful disregard of warnings of the consequences. In my experience there are few mothers or guardians of young girls who instruct in the necessary way those under their charge in this most important matter. This often appears to be a mere question of neglect, but I am certain it is also very often from a shame-faced aversion on the part of mothers to discuss such matters with their daughters, and so a most important source of influence and a bond of confidence between mother and daughter are never acquired. If the young girl has to learn of this matter from friends and companions

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of her own age, or from mature women other than her mother, she may also learn from them other things she had better not have known.

There would doubtless have been little difficulty in further pursuing this line of thought. Suffice it to say that I have indicated mistakes the most common in my experience, and the most serious in their results, and if it be thought by some who have heard me that something is due in self-defence for the selection of such a subject as that I have chosen for this address, let it only be that it is in some measure a confession. I have included in the list, mistakes of my own, humiliating enough they have been, as well as those of others.

"THE cases I have recorded seem to show that the operation of utriculoplasty is a legitimate alternative to hysterectomy in the treatment of intractable uterine hæmorrhage due to the condition variously known as 'hæmorrhagic metritis,' 'chronic fibrotic metritis,' and other similar terms, and also that it is feasible to apply it to a uterus the seat of small multiple myomata. It would appear to be preferable to hysterectomy when the patient is still of child-bearing age, and the cervix is reasonably healthy, and especially if the patient herself objects to an enforced abolition of the menses. In the reverse of these conditions removal of the uterus is the more suitable operation—by total hysterectomy if the cervix be unhealthy, by subtotal hysterectomy in all other cases. In the event of pregnancy following utriculoplasty it would, I think, be desirable to induce the labour some weeks in advance in order to lighten the work of the uterus."—*The Lancet.*

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