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PITFALLS IN THE PRACTICE OF GYNECOLOGY AND OBSTETRICS.*

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DR. BEACH, as president of the Brooklyn Gynecological Society, has requested that I choose a subject for discussion before your county society that will be within the scope of the general practitioner and in compliance with his request I will discuss with you some of the unapparent sources of danger whch I have encountered in my score of years of work in the field of gynecology and obstetrics.

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Those of you who are familiar with Methodist Camp Meetings know something of the satisfaction the audience feels, when the other fellow lays bare his sins and it has occurred to me that I am far enough removed from home to afford to disclose to you some of the hidden snares into which I have fallen. I beg to assure you that I will do so with never a suspicion that you, too, have met with similar disasters. It may be that my opportunities for observation have differed from yours, somewhat, in that they have not been confined to the conditions which are encountered in the institutions and homes of cities but have extended into rural districts where facilities for work are more or less primitive.

My saddest disappointments have to do with the problem of malignancy. Why am I so often confronted with cancer of the uterus in the inoperable stage? I can recall but two cases of cancer of the cervix in the past twelve years that gave so much as a reasonable assurance of complete and lasting recovery following a radical operation. For twenty years I have instructed my students and have preached in season and out of season to the medical profession the only doctrine in which I have any abiding faith—that of early diagnosis and prompt surgical intervention in these cases. And yet the old notions prevail among the profession as well as the laity that irregular and profuse bleedings are a necessary concomitant of the change of life. In looking over my records of cases in which there is excessive and untimely losses of blood in the climacteric I find only one case in sixty is actually malignant. This would be encouraging were it not for the fact that this one case in sixty is so often permitted to go the way that leads unto death until the doctor and patient finally conclude that there may be something wrong after all. We make systematic urin analyses of all cases and in so doing we do not disclose an unsuspected lesion of the kidney in one case in sixty. Why should we not make the necessary examinations in all cases of climacteric bleeding to the end that the one case in sixty will not go unrecognized while it is yet time to save life? It is questionable if the gneral practitioner should trust to his cunning in the early recognition of cancer of the uterus, but surely he can advise his patients that any irregular loss of blood, however slight, after 40 years of age, is suggestive of the presence of cancer and he can advise them to lose no precious time in submitting to the necessary examination by a competent clinician and laboratory expert. I would remind you that an odorless, watery vaginal discharge in the advanced years of life is as suggestive of cancer as is loss of blood. To wait for loss of flesh, odorous discharge and pain is to wait too long. It may fairly be stated that there are no symptoms in the earliest stage of cancer of the cervix. Possibly ten percent of all cases are inoperable when loss of blood and watery discharges make their appearance. Pain is the result of cancerous invasion of the parametrium and is not present so long as the cancer is within the confines of the cervix; hemorrhages and foul discharges speak for degenerative changes and advanced growth. And so we come readily to the conclusion that if we are to cure our cancer cases we are to lose no time in arriving at a diagnosis that will admit of no doubt at the very onset of suspicious symptoms. In this connection I would decry the growing practice of applying the X-rays or radium to climacteric hemorrhages without first doing an exploratory curettage together with the microscopic examination of scrapings and

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excised pieces. I recently operated a case that had lost six precious months in X-ray treatments. A cancer of the body of the uterus had invaded the peritoneal cavity. Nero was fiddling while Rome was burning.

A survey of my records of cases of both acute and chronic pelvic infections brings to light some problems which may interest you. In the first place I note a marked decrease in the percentage of operability of these cases in recent years. In the earlier years about twenty percent of all cases operated were pelvic infections. They included so-called endometritis, salpingitis, metritis and pelvic abscesses. Now less than five percent of these cases are operated. And why? Because I have learned that a symptomatic cure is possible in the majority of these cases without resort to surgery and I find that my percentages both in loss of life and in failure to restore health were larger in this class of cases than in any other class save that of malignancy. Now we no longer scrape the infected uterus and we avoid opening the abdomen for pelvic infections of whatever nature until all evidences of active infection have subsided. If we follow this rule religiously there will be fewer cases operated and this will mean not only fewer operations but less sacrifice of important structures; lives will be safeguarded, there will be added years of comfort for these patients who are spared organs essential to their well-being and they will have escaped postoperative sequelae which are often more distressing than the original disease. In the treatment of purulent discharges from the uterus I have tried all the measures that are commonly employed and have failed utterly. I have learned that the curet in such cases is worse than useless—it is a positive danger; I have learned that swabbing and injecting into the uterus whatever antiseptic or escharotic one may choose is meddlesome and I have wholly discarded the filthy icthyol and glycerine tampons. For a few years I simply gave it up and instructed the patient to take vaginal douches. But about three years ago my attention was called to vaginal packs with Fuller's earth by Dr. George Gellhorn of St. Louis. I tried them and in these three years I have never failed to cause these leucorrhoeal discharges to disappear with the exception of two cases where the uterus was not only infected but the uterine appendages as well. With the removal of the tubes, these cases readily responded to the treatment. I do not know how Fuller's earth does the business—I only know that it does. The method of applying the Fuller's earth consists in introducing a Ferguson speculum, filling it with Fuller's earth and forcing a tampon through the speculum as the speculum is withdrawn. At the end of six to eight hours the tampon is removed and a vaginal douche taken. I direct that three Lysol douches be given at intervals of six or eight hours and that the treatments be repeated daily. As a rule the cases respond to the treatment with eight or ten applications. In some of the aggravated cases it has been advisable to keep them in bed throughout the course of the treatments. I have dwelt at length on these treatments for leucorrhoeal discharges because they do get results and I know of nothing else that will serve the purpose.

I have referred to the management of infections involving the uterine appendages and I may add the pelvic connective tissue as well and I have argued for the conservative management of this class of cases. May I add that with the exception of cases in which

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there is an accumulation of pus within the pelvis that can be readily drained through the cul-de-sac I believe that results will be forthcoming just as speedily and as perfectly if absolutely nothing is done but to enforce rest in bed. I do not believe there is any virtue in douches, vaginal packs of any sort or external applications to the abdominal wall. Time and rest will bring about absorption of inflammatory exudates and a symptomatic cure will follow in a large proportion of cases. It is time for the consideration of surgical intervention when the inflammatory exudate has absorbed, when the infected appendages have become sharply circumscribed, when after gentle pelvic massage there is no rise of temperature above the normal and above all when time which may lengthen out into months or years has failed to bring relief from distressing symptoms. I have been forced into this ultraconservative position in relation to pelvic inflammations by many an embarrassing experience in which my patients have refused operation and have subsequently found complete relief by simply doing nothing but keeping away from the surgeon.

I want now to revert to the subject of Cesarean Section as I have encountered it in a consultation practice which has brought me more or less intimately in touch with a territory covering several of our midwest states. Many cases have been spoiled for the doing of a conservative Cesarean Section because of delay in interfering until the patient has reached the stage of obstetric exhaustion and because repeated vaginal examinations and attempts at delivery had rendered the patient liable to infection. I have learned through bitter experience that in event of exhaustion or of probable or known infection to set aside all consideration for a conservative Cesarean Section and to substitute the more radical Poro-Cesarean or the Vaginal Cesarean when the delivery of a living child cannot be effected through the natural passages. And in occasional instances it has been necessary to impose craniotomy on the living child as the only means of safeguarding the interests of the mother. The opportunity for the doing of a conservative operation was lost for lack of appreciation of the obstetric problems which presented themselves before labor or at the onset of labor. To follow with mathematical precision the progress of labor, to judge unfailingly the powers of labor and the resisting forces to the progress of labor is a high art and one that is seldom attained. If there is one thing I have learned it is this—that a woman, if given a chance, will overcome obstacles in childbirth that at first seem insurmountable. Judgment, however, must be based upon accurate knowledge of all existing conditions affecting the mother and child—otherwise the time for interference and the manner of interference may not be recognized while it is yet time to render the best possible service.

If indications for conservative Cesarean Section are not always recognized; if valuable time has been lost in fruitless efforts to deliver the child by other means; if meddlesome interference in one way and another has made the operation impossible what may be said of the needless Cesarean Sections that are being done in increasing numbers all over our land? I feel very deeply on this question and I find it very difficult to speak dispassionately upon the subject.

As compared with many of the difficult obstetric procedures abdominal Cesarean Section is all so easy. It is a short cut procedure that calls for the exercise of the minimum skill and brings as its

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reward much coveted notoriety and monetary consideration. Too often it is the general surgeon who performs the rôle of the expert accoucher and he performs badly. He chooses his weapon according to his cunning rather than follow the teachings of the old masters of midwifery. If the child cannot find its own way out by way of the natural passage it may not occur to him that a little well directed assistance might help it on its way. If ever he familiarized himself with obstetrical manipulations he no longer looks with favor upon them. Why follow the teachings of Smellie, of Braxton Hicks, of Chamberlain and Simpson when he can apply his skill in abdominal surgery to so good an advantage to his patient and himself? And so contracted pelves of low degrees, placenta previa of whatever variety, eclampsia, brow, face, breech and transverse presentations, delayed labor from causes known and unknown and even the pampered society woman who would be spared the nerve exhaustion incident to labor are to him all alike a justification for choosing the abdominal route.

I would plead that we return to the teachings of the old masters in obstetrics, that from this common ground we make a new start and that we hold fast in our faith in the ultimate triumph of Nature's forces; assisting them when need be but never going contrary to them unless they fail us utterly.

Shortly before the beginning of the present war I was doing some obstetric work in a certain frauenklinik somewhere in Germany. There was much to admire in the management of the cases in the clinic. The diagnostic work was admirable and the cases were handled with the utmost regard for surgical cleanliness. Yet thirty percent of all cases delivered were infected. I worked in the delivery room and walked the wards daily and in time I came to the conclusion that this appalling high rate of sepsis could only be accounted for by the multiplied vaginal examinations to which every patient was subjected. Hands were scrubbed most thoroughly, antiseptic hand solutions were used and dry sterile gloves were worn. Furthermore, every student was rigorously disciplined in the cleansing of the vulva before inserting the examining finger. And yet nearly one case in three developed a temperature of 101 to 105 degrees. It was a teaching clinic and there were undergraduate and postgraduate students to be instructed, not to mention two or more assistants. Each in his turn made a vaginal examination upon every woman in the second stage of labor and if the labor was prolonged the rounds were made again and sometimes again and again. Here I believe you have the answer for a large percentage of puerperal infections not alone in this particular clinic but in private practice. We have all seen infection develop in cases that delivered themselves without so much as a single examination but such instances are extremely rare.

Repeated vaginal examinations seldom serve any good purpose. Of late years I have not made a single vaginal examination in one case in twenty. As a rule I am entirely satisfied with my findings in abdominal palpation and rectal examination. By rectal examinations it is possible to accurately determine the progress the presenting part is making through the pelvis, the fixity of the head and the degree of effacement and dilation of the cervix. Couple the knowledge gained by rectal and abdominal palpation with the judicious administration of pituitrin and vaginal examinatons and the applica-

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tion of forceps will be reduced to the minimum to the betterment of our statistics in puerperal infections.

I wish I could add that the profession has unanimously adopted the doctrine of non-surgical interference in the management of puerperal sepsis. There are those who still curet and douche the uterus with the result that an infection which might otherwise have remained limited and relatively harmless now becomes widespread if not fatal. Almost all septic cases which end in death have been tampered with. So convinced am I of this fact that I count myself fortunate in my consultation work if I can see the case in time to stay the hand of the attending physician and thereby prevent the breaking down of Nature's barriers round about the infected zone. Fresh air, nourishing food, rest and careful nursing will do about all that can be done for these cases and all intrauterine manipulations jeopardize the interests of these patients.

In closing may I not express the conviction that better obstetrics is being practised today than in the past and with each step forward in the management of obstetric cases there will be less gynecology for as someone has said, "Gynecology is a parasite that thrives on bad obstetrics."

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