A CONSIDERATION OF CERTAIN GYNECOLOGIC PROCEDURES

FROM THE STANDPOINT OF CONSERVATISM

C. JEFF MILLER, M.D., F.A.C.S.

NEW ORLEANS

THE safety of anesthesia and the refinements of surgical technique, which we are wont to regard as among the chief blessings of the modern era of medicine, carry with them inevitable penalties. The very simplicity with which a laparotomy can be performed today is a potential source of danger. Because the mortality which follows the average surgical procedure is no longer such as to make one hesitate before he resorts to the knife, there is a tendency on the part of many to feel that the niceties of diagnosis are no longer as essential as they once were, and that the indications for surgery need not be so clear cut. Gynecology shares in this very doubtful tendency, and it is becoming unfortunately rather general to regard it as almost exclusively a surgical specialty, and to forget that many times simpler measures are quite as effective, and considerably safer for the patient.

Conservatism, however, is an entirely relative term. Speaking categorically, the preservation of structure and function is always to be preferred to their destruction, but mere abstinence from surgery is not necessarily conservative. Indeed, I have seen cases in which the apparently simple application of radium, even without anesthesia, was considerably more radical than a complete hysterectomy would have been.

The main error lies in the assumption that because a certain pathology is present, a certain procedure must inevitably follow. Thus a fibroid presupposes a hysterectomy, just as a retroversion presupposes a suspension. Such a mechanical standardized way of thinking is disastrous for the patient. True conservatism is only possible when each patient is individualized, when not only the pathology present is considered, but also its degree and its duration, and when even such non-medical factors as the age, the social condition and the financial status are also weighed and balanced.

It is well to remember, too, that any induction of anesthesia, any operation, even the most minor, carries with it a perfectly definite morbidity and mortality, which increase in direct proportion to the extent of surgery done. It is comforting to reflect that the mortality of hysterectomy, for instance, is not more than 2 per cent (though the qualification that this is so only in the best clinics is too frequently forgotten) but the law of averages is of small assistance unless we remember that each individual shares in its composition, and that he is quite as likely to figure in the debit column of deaths as in the credit column of recoveries.

Just as cesarean section has become the most abused operation in obstetrics, so has hysterectomy become the most abused operation in gynecology, and for exactly the same reason, its ease of performance and its brilliant end-results—provided all goes well. Naturally it is definitely indicated under certain circumstances, but it is not a cure-all for every type of pelvic disease, and it is no more logical to perform it routinely for pelvic pathology than it would be to amputate the hand for a broken bone.

Hysterectomy for uterine bleeding, for instance, is seldom warranted today unless actual uterine pathology is present. In the first place, such bleeding is as often due to extrauterine as to intrauterine

conditions. Constitutional diseases, adnexal pathology, general debility and lowered resistance, and endocrine dysfunction all, in the light of modern knowledge, play an important part in the production of uterine hemorrhage, and it is well to be certain that none of these is responsible before the uterus, which is often merely responding to the evil stimulus of disease elsewhere, is removed. Likewise one cannot be too careful to eliminate pregnancy as a possible source. Few things are more humiliating than to perform a hysterectomy and to find an unsuspected early pregnancy, or a threatened or incomplete abortion. In studying a large series of cases it is surprising to note how often this happens, and how often the uterus is entirely negative or exhibits merely a fibrosis or hyperplasia.

The use of the curette as a diagnostic measure, followed by frozen sections, cannot be too highly recommended as a routine procedure before hysterectomy is done for any hemorrhagic uterine condition. Occasionally it is curative. If it is not, and the bleeding persists, radium is practically a specific for fibrosis, chronic metritis, uterine hyperplasia and uterine insufficiency in women advanced in years, and even in young women and in girls it may be used in graduated doses to produce a temporary amenorrhea. As Howard Kelly long ago pointed out, it is notoriously difficult to stop menstruation in early life, even when you want to, and the advocates of hysterectomy for these benign conditions certainly possess no magic by which they can perform hysterectomy and at the same time preserve function.

Again, the mere presence of a fibroid does not mean that any treatment at all is necessary, let alone hysterectomy. A symptomless tumor, discovered accidentally in the course of an examination, needs only routine observation. Even fibroids which are causing symptoms do not necessarily demand hysterectomy, and the possibilities of myomectomy and irradiation should always be weighed before it is proposed.

Myomectomy is an operation whose field will always be strictly limited, but it can be used more often than is generally supposed, especially in private practice. During a limited period in my private work in which I performed 40 hysterectomies, 24 of them for fibroids, I was surprised to find from my records that I had done 26 myomectomies. On my service at Charity Hospital, however, during the same period, there was but one patient in whom the procedure was possible.

Myomectomy is best adapted to the single subperitoneal tumor, though multiple tumors of all types may thus be removed, providing that the uterine musculature is not too seriously damaged by the existing pathology or the surgery necessary to enucleate the growths. Since the whole point of the operation is the preservation of function, it is seldom indicated after the menopause, or when pelvic disease makes it necessary to remove the adnexa also. In competent hands the morbidity and mortality are no higher than they are for hysterectomy, and the results, from the angle of preservation of function, are excellent. More than 90 per cent of the patients menstruate normally thereafter, only a minimal number of the tumors recur with symptoms, and there are from 20 to 30 per cent of subsequent pregnancies. The latter is a particularly good record if we consider the various factors which enter into the question of sterility, aside from the undoubted fact that many of these women frankly do not want children.

Irradiation has a decidedly limited field. Since it most often means the destruction of function, it is seldom the procedure of choice in women under thirty-eight or forty if any measure short of hysterectomy will accomplish the desired results. In women beyond that age it is the ideal treatment in selected cases of interstitial myomata of moderate size, either single or multiple, in which bleeding is the chief symptom. Both tubal and ovarian disease must be eliminated, and it must be clearly ascertained that the growth is not under-

going degenerative changes. In any case which meets these conditions, however, one is usually safe in saying that radium is indicated and that hysterectomy would be an unwarranted procedure.

There is at least one exception to the foregoing remarks. Hysterectomy is the wisest procedure, even in young women, in fibroids when myomectomy is not possible, or in intractable menorrhagia or dysmenorrhea. From the standpoint of function irradiation is quite as irrevocable a procedure as hysterectomy, and it may give rise to very much more serious consequences than will follow the surgical ablation of the uterus and the preservation of functioning ovaries.

Routine removal of the ovaries after hysterectomy cannot be too strongly condemned. I am aware that the final facts are still in dispute as to the fate of the ovaries after hysterectomy, but my own experience, which is verified by that of other observers, is that their preservation is always warranted if they are not definitely diseased. It is beyond question that the violent symptoms and even the occasional nervous unbalance which may follow an abruptly produced artificial menopause are modified, and that the symptomatology of the delayed menopause, when it does occur, compares very favorably with that of the normal menopause.

As a general rule, the uterus should always be preserved unless there is some intrinsic reason for its removal. It may be a functionless organ after bilateral salpingectomy, for instance, in that conception cannot occur, but if the ovaries can be preserved and menstruation is still possible, the psychic effect, at least, would warrant its conservation. Naturally if the adnexa must be removed in toto, or if the uterus itself is diseased or is so denuded during operation that it would be virtually a useless organ, these arguments do not hold.

Hysterectomy for hydatidiform mole is an unwarranted and illogical procedure. Fifty per cent of all cases of chorioepithelioma do follow moles but this type of malignancy is extremely rare, and the reverse of the statement, although it is often advanced as a fact, is by no means true, for 50 per cent of hydatidiform moles do not develop into chorioepitheliomata. Routine, careful observation is obviously indicated, and diagnostic curettage should be done promptly if symptoms recur, but radical surgery as an initial procedure has no justification whatsoever.

Diseases of the cervix are often handled by measures far too extreme. The proper time to treat cervical injuries is just after they occur, that is, when they are detected in the final examination which should always be made from ten to twelve weeks after delivery. At that time even moderate tears, with the accompanying erosion and eversion, may be successfully handled by the electrocautery, either in the office, or, if necessary, in the hospital under anesthesia, and the employment of this simple measure will in most cases avert what might develop into an intractable endocervicitis with its train of major and minor sequelae. Extensive tears should be promptly repaired surgically, without regard to the baseless tradition that plastic surgery should not be done in women in the childbearing years.

Moreover, even when treatment has been delayed and the cervix is apparently so diseased that only amputation is possible, a preliminary course of treatment will often change the entire aspect of the case. Rest in bed, hot douches, postural exercises, local applications, even cauterization and puncture of cysts will frequently so restore the parts to normal that less radical measures, such as trachelorrhaphy or the Sturmdorf or Schroeder operation, will be found perfectly feasible. Amputation of the cervix is always a radical measure, and the end-results in young women particularly are so generally unsatisfactory that it should be an exceptional and not a routine treatment for cervical disease.

It is beyond question that occasionally

retroversions of the uterus are symptomless and that their correction falls therefore into the class of unnecessary surgery; but in the majority of cases this is not so and some treatment is warranted. It does not follow, however, that it need be surgical. Retroversions which are detected shortly after delivery may often be corrected by the application of a Smith or a Hodge pessary, and this simple measure certainly deserves a trial before operation is resorted to. It is well to remember, too, that because backache is associated with retroversion, it does not necessarily follow that it is due to it. Arthritis, neuritis, kidney disease, sacroiliac strain, traumatism, even bad posture, may all be responsible, and it is wise to eliminate them before the patient is promised relief by surgery. Likewise retroversions play only a minor part in sterility, and suspension operations performed solely for the relief of this condition are not usually justified by their results.

Immediate operation for tubal disease is in most instances radicalism of the most extreme type. Salpingitis is essentially an infectious disease, in which autosterilization takes place in the majority of cases, and in which spontaneous clinical recovery and even functional restoration are possible. Immediate operation, therefore, quite aside from the admitted risks of surgery in the face of an acute infection, obviously means that a certain number of unnecessary operations will be performed. In addition, surgery done at this time must usually be radical, since the involvement of the pelvic organs is general and localization has not occurred. Plastic operations on the tubes are only occasionally possible, and even then the end-results, from the point of view of function, are almost uniformly unsatisfactory. Also studies of a large series of cases operated on during the acute stage will show that radical removal of the adnexa and even hysterectomy are too generally done to warrant the advocates of this procedure pleading for it on the ground of conserving structure and function. Finally, the woman who recovers clinically under expectant treatment, even though she does not conceive, is no more absolutely sterile than the woman whose tubes were removed at laparotomy during an acute attack. As a matter of fact, the percentage of subsequent pregnancies under expectant treatment is larger than is generally supposed; Holtz, for instance, has recently reported it to be 12 per cent in a series of more than 1000 cases of his own.

I have been interested also to note how invariably the morbidity and mortality after operation for tubal disease increase in proportion to the length of time the case is cooled. Thus in a series of 600 consecutive operations which I recently investigated from the records of Charity Hospital and Touro Infirmary, three-quarters of all postoperative complications were in uncooled cases, while the death-rate in them was more than 4 times as high as in the cooled cases. Since these 600 cases were done by 57 physicians, they are rather more representative than DuBose's series of 419 cases in which immediate operation was done. The death-rate of one in the latter group is extraordinary, but the entire series was done by one man, and an expert at that. The statistics I have quoted are not mere coincidence. They have been substantiated from other clinics and by other observers.

It is obvious from instances such as I have discussed—and they could easily be multiplied—that there are at least two very dangerous tendencies in gynecology today. One is the tendency to resort to surgery without a careful consideration of simpler non-surgical measures, which might give equally good results with less inconvenience and less risk, and to perform major surgery for minor conditions. The other is the promiscuous and causal removal of the female sexual apparatus on the most trivial indications. Since this is not ordinarily a procedure which endangers life, function is lost sight of, comfort is disregarded, sentiment is thrown to the winds, and unnecessary and multilating

radical surgery is done without a consideration of other more conservative modes of treatment. Howard Kelly was right when he said that surgery developing in the hands of men had dealt too lightly with mutilating operations in women, and that if the case might be reversed for several decades, with women operating and men suffering the mutilations, there would be a large prepossession in favor of wise conservatism. At any rate, in gynecology, as elsewhere in medicine, the end-results will always be better if the patient be considered as an individual rather than as a lay figure on which to demonstrate machine-made diagnoses and standardized treatment, which too often involves also a display of surgical fireworks.

Priestley has described the history of gynecology hitherto as a series of "crazes," a tendency to follow prevailing fashions. The uterine displacement craze came first, with Hewitt in England, Velpeau in France, and Hodge in America championing the pessary for the treatment of bachache or pelvic pain, and every gynecologist inventing or modifying one himself; the unfortunate uterus all the while was, as Allbutt says, either "impaled on a stem or perched on a twig." In 1857, Gustave Bernutz found a case of periuterine abscess due to inflammation of the pelvic cellular tissue, and thence the pelvic cellulitis craze; on this Bernutz and Goupil published their famous memoir in 1862. Pelvic pathology was viewed largely from this vantage point until in 1880 Gaillard Thomas exploded it by showing that much so-called cellulitis is really peritonitis, and rare in virgins. Similarly, such conditions as oophorectomy, clitoridectomy, inflammation of the os and cervix uteri, excision of the uterus and its adnexa, operations for extrauterine pregnancy, and cesarean section all had their day, following the dictates of fashion.