

**CUSHING (C.)**

**GYNECOLOGY**

AT THE

Lane Hospital, San Francisco.

BY

CLINTON CUSHING, M. D.

SAN FRANCISCO.

*Professor of Gynecology in Cooper Medical College, Fellow of the American Association of Obstetricians and Gynecologists, Fellow of the British Gynecological Society, Consulting Surgeon to the French Hospital, etc.*

(READ BEFORE THE MEDICO-CHIRURGICAL SOCIETY OF  
SAN FRANCISCO, JUNE 1, 1896.)

WOODWARD & CO. PRINTERS, SAN FRANCISCO





# GYNECOLOGY

AT THE

LANE HOSPITAL, SAN FRANCISCO.\*

Service of PROF. CLINTON CUSHING.

The following is but a partial report of the gynecological and abdominal surgery done in the hospital since it was opened last year. Numerous operations have been done there by other members of the staff, and also by surgeons not connected with the hospital.

The accompanying table includes all the cases under my personal care during the past nine months. And were of all nationalities and from all parts of the country, from British Columbia to Central America.

Nature of Case.	No. of Cases.
Cancer of rectum.....	2
Fibroid tumors of uterus.....	5
Fibro-cystic tumor of uterus.....	1
Fibroid polypus of uterus.....	1
Intra-uterine sloughing of fibroid.....	1
Cancer of uterus.....	1
Ovarian cystic tumors.....	3
Prolapse of ovaries with fixation.....	3
Retroversion and fixation of uterus.....	3
Subinvolution of uterus.....	6
Chronic endometritis.....	12
Hydrosalpinx.....	1
Pyosalpinx.....	10
Cystic disease of cervix.....	2
Pelvic peritonitis.....	10
Hysterorrhaphy.....	8
Nephorrhaphy for floating kidney.....	2
Cystic tumor of broad ligament.....	1
Abdominal fistula, following operation.....	2
Dyspareunia.....	2
Laceration of cervix.....	16
Laceration of perineum, partial.....	17
Laceration of perineum, complete.....	2
Fissure of anus.....	2
Chronic urethritis.....	2
Enterectomy for cancer of ascending colon.....	1
Appendicitis.....	1
Menorrhagia.....	4
Hemorrhoids.....	3



\* Read before the Medico-Chirurgical Society, of San Francisco, June 1, 1896.



Nature of Case.	No. of Cases.
Ventral hernia.....	2
Exploratory incision for enlarged liver.....	1
Vesico-vaginal fistula.....	1
Vaginal fixation of uterus for retroversion.....	5

As will be seen, nearly all the surgical diseases peculiar to women are represented. And it is with much satisfaction that I am able to state that the results have been good.

The hospital is new and clean, and the occurrence of suppuration in newly made wounds is rare. Whether the time will ever come when suppuration can absolutely be prevented in fresh wounds, in all cases, is problematical, for the general state of the patient must needs be considered, as well as the appliances and technique of the surgeon.

As far as possible, all sources of infection have been sought out and corrected, but the avenues through which infectious matter may be introduced during a serious and prolonged operation are myriad in number, and a sleepless vigilance and a most untiring and painstaking care is necessary in order to accomplish desired results. Indeed, I doubt if any one who has not undertaken in a systematic way to prepare for a surgical operation can fully understand how much labor and thought and attention to details are requisite for success.

Briefly, the hands both of principal and assistant are carefully cleaned with soap and hot water, then placed in a strong aqueous solution of permanganate of potash, then decolorized with a saturated solution of oxalic acid in warm water, and lastly soaked in corrosive sublimate solution, one to one thousand.

The instruments are boiled in an alkaline solution, and the ligatures and sutures are boiled for three hours in alcohol.

Where the case is one of abdominal section, the patient is given a mercurial purge, and for forty-eight hours is permitted to have only fluid food, such as broths, well boiled gruel, with milk ad libitum, tea, coffee, and cocoa, the object being to have as little decomposing material in the alimentary canal as possible at the time of the operation, and thus avoid the distension with gas which is often a troublesome symptom in intra-peritoneal surgery.

The skin and mucous membranes at the site of the operation are made clean by scrubbing and the liberal use of soap and water, and the skin of the abdomen is covered for twelve hours with a compress saturated with a solution of 1 to 1500 corrosive sublimate in alcohol. For obvious reasons, all hair

at or near the site of operation is shaved off, the day before, or at the time of etherization.

The longer the patient is under the influence of the anesthetic the greater the shock and danger, therefore the more speedily the operation is finished, consistent with good work, the better. This is particularly true in cases of intra-peritoneal operations.

I use Squibb's ether altogether for anesthesia, except in cases of pronounced disease of the kidneys, or in the aged who are disposed to bronchial disease, in which case the A. C. E. mixture is used.

I am of the opinion that ether is the safest anesthetic, especially in prolonged operations, and also in operations about the perineum and anus; for it appears that this part of the body is the last to lose sensibility, as is easily proven, for when the conjunctiva is quite insensible and the body perfectly relaxed, the tissues about the anus and perineum still remain sensitive, as evidenced by the struggles of the patient when an examination of the part is undertaken. The conclusion drawn from this is that a patient chloroformed to a degree that the perineum is insensitve is nearer the danger line than if ether is used, for ether is a stimulant and chloroform is not.

The method of examining the urethra and bladder perfected by Kelly, of Baltimore, I believe will prove a valuable addition to our means of diagnosing and treating affections of these parts. To one unacquainted with the procedure, it is an agreeable surprise, and it is the only practical and satisfactory plan I have ever known. The examination of the bladder cavity and the urethra is easily made by any one at all familiar with the use of the head mirror or the electric lamp, and the application of remedies correspondingly easy. The catheterization of the ureters, while quite simple in the hands of Dr. Kelly, or an expert, is difficult for one unused to it. While my experience is limited, I believe I can see a large field of usefulness for Kelly's instruments in the future.

Kelly's instruments for examining the rectum are made and used on the same principle, and we have found them a valuable addition to the hospital armamentarium.

I would again invite attention to the plan I pursue in plastic operations about the vagina, bladder, cervix, and rectum.

So convinced am I of the advantages of my method, based



as the opinion is upon practically uniform good results, that I do not hesitate to reiterate my former statements. The principle involved is an exceedingly simple one, *i. e.*, after the operation is finished, that the parts involved shall be let absolutely alone for eight days, or until the healing process is complete.

This plan applies especially to vesico or recto vaginal fistulas, and to complete laceration of the perineum, and consists in filling the vagina with freshly prepared oxide of zinc ointment, to each ounce of which has been added a grain each of morphia and cocaine. A large teaspoonful is also inserted into the rectum. This is done immediately upon the completion of the operation, the ointment being introduced with an ordinary teaspoon,—except in cases of complete laceration into the gut, in which case an ointment syringe is necessary to introduce the ointment into the rectum, in order not to disturb the recent operation upon the external sphincter.

Several important advantages are gained by this procedure,—firstly, the woman suffers practically no pain, and rarely is it necessary to administer any remedy on account of suffering. Secondly, no injection or handling are needed, and the newly apposed surfaces have the quiet and rest so essential in plastic operations.

The urine, which should be passed, if possible, in the usual manner on a bed pan, cannot enter the vagina or come in contact with the wound on account of the ointment. No vaginal injections are permitted—unless there be fever or offensive discharges—for eight days, but after each urination the external parts are douched off with a quart of warm carbolized water, and some fresh ointment applied just above the site of the operation between the labia, and as it melts it coats over the parts and renders the woman comfortable. By this plan, healing by the first intention is almost certain, if the operation has been properly done. *Pabia*

So true is the statement regarding pain, that I have done vaginal fixation of the uterus for retroversion, repaired a laceration of the cervix and perineum, and removed hemorrhoids, all at one sitting, in the same patient, and no narcotics were used except what was contained in the ointment, and the pain was rendered tolerable.

The absorption of the cocaine and the morphia is so gradual that the desired effect is produced without the use of additional drugs.

In repair of the cervix, I have given up the use of scissors entirely, the knife being greatly superior.

All lacerations of the perineum, both complete and incomplete, were repaired by the flap-splitting method. And the results have left nothing to be desired.

There is much difference of opinion regarding suture material. For various reasons, silk-worm gut is the most satisfactory, notably its strength and flexibility, and its not being absorbable and not irritating to the tissues. Occasionally cat gut and silk have been used for buried sutures.

Of the two cases of complete laceration into the gut, one was of three months standing and the other of eighteen years. In the recent case, an effort had been made to repair the damage at the time of its occurrence, but without success. In the other case, the attempts had been made by different surgeons to effect a cure, but apparently nothing had been gained by the effort.

In both cases, the flap-splitting method suggested by Lawson Tait was adopted with the happiest results. Continence was perfectly restored, and the perineum was as good as new.

It is undoubtedly of the greatest importance that the contents of the alimentary canal be thoroughly cleared out before the operation, in order that no hard masses of fecal matter come down upon the newly repaired sphincter until it becomes firmly healed.

The plan pursued is to give a laxative pill containing two grains of extract of aloes and one-third grain of nux vomica every night at bed-time for a week, being followed each morning by a tablespoonful of castor oil; in the meantime the diet being strictly fluid broths, with rice boiled in them, gruel, etc.

In this manner, the large intestine becomes thoroughly emptied.

Following the operation, the bowels are moved every second day by giving a seidlitz powder every hour until a free evacuation occurs; and, being watery, passes easily and without pain. The silk-worm gut stitches are removed on the eighth day, the perforated shot with the black tags of silk thread rendering this procedure an easy one. As all are aware, the important point to be gained by the operation is the restoration of the functions of the external sphincter ani. And this can only be done by cutting the ends of the broken muscle squarely across, and then carefully adjusting the freshened ends and securing rest for the parts, so as to get union



by the first intention. While this statement seems simple, to be successful, skill and experience are usually requisite.

The fibro-cystic tumor was one of the largest on record. It weighed eighty pounds, and contained about seven gallons of greenish-yellow pus. It had been tapped several times, and this doubtless caused the suppuration. The bladder was carried above the umbilicus by the growth of the tumor, and was wounded during the operation. The patient died of shock at the end of twenty-four hours.

The surgical treatment of uterine fibroid tumors varies according to the nature of the case. The small sub-peritoneal tumors were shelled out, and the incised peritoneum was united with catgut. Where a pedicle could be easily made of the cervix, in cases of large fibroids involving a large part of the uterus, the stump was treated externally.

Where the tumor was low down in the pelvis, the bladder was dissected off, and, after tying the ovarian and uterine arteries, the cervix was divided, the body of the uterus with the tumor removed, the cervical canal cauterized, and the opening in the peritoneum closed with a whip stitch of catgut and the abdomen closed in the usual way.

Further observation leads me to the conclusion that operations for uterine fibroids are not infrequently undertaken by surgeons where there is no warrant for such procedure.

The simple fact of the existence of a fibroid tumor of the uterus is certainly no excuse for its removal if it produce no untoward symptoms.

As is well known, a large proportion of women who live to be forty years of age, and who remain sterile, have uterine fibroids of greater or less size. These tumors frequently cause no symptoms whatever, and their existence is often only discovered by accident. When to this is added the fact that fibroid tumors of the uterus frequently undergo atrophy after the menopause, or at least cease to enlarge, it would appear to me that the only warrant for a surgical operation for their removal would be serious pain, hemorrhage, or disturbance of the functions of the adjacent organs on account of pressure.

To open a woman's peritoneal cavity and perform a surgical operation for the cure of a uterine fibroid that is causing no pain or disturbance, seems to me a risk that no intelligent and conscientious man would subject his patient to. Indeed, I believe it to be little short of criminal.



I am the more willing to say this because I believe a halt should be called in the craze that has been going on for operating on every poor woman who has any sort of a uterine fibroid tumor. I think it better that new schemes and methods be sought out by which we may avoid operations, rather than the invention of new ones. Nevertheless, where the health or life is at stake, or the health so impaired as to render life a burden, I am as willing to take grave risks in the effort to cure as most men, as my record in this city abundantly testifies. I had hoped that Apostoli's method would prove to be a satisfactory plan; but the pain and hemorrhage and the long period of treatment, as well as its somewhat uncertain results, and the fact that it was not devoid of danger, rendered it unpopular both with physician and patients.

When the ovaries are prolapsed into Douglas pouch, and fixed there by adhesion, a condition exists that is a *bête noir* to physicians. The ovary is usually extremely painful to the touch, the sexual relations are intolerable, the menstruation is painful, the movement of feces through the rectum causes suffering, and the backache and inability to stand or walk, together with the demoralized state of the nervous system, altogether make up a state of things that is disheartening both to physician and patient. The uterus is commonly retroverted, and fixed as well, and the Fallopian tubes, usually enlarged and diseased, accompany the ovaries in their unnatural position.

The usual treatment of packing the vagina, with the woman in the knee-elbow posture, frequently benefits, but does not cure. And the tearing the ovary loose by using great force, while the patient is under an anesthetic, is attended with great danger of causing a peritonitis by lacerating the diseased Fallopian tubes.

The plan I have pursued for the past ten years has been to open the abdomen above the tubes, introduce two fingers, and dissect up the adherent organs with the finger tips, and then remove such diseased ovaries and tubes as were manifestly of no further use. If the ovaries were in fair condition, they were stitched to the top of the broad ligament near the uterus, and, where needed, the uterus stitched to the anterior abdominal wall.

On the whole, this plan has worked well. It has relieved the troublesome symptoms, and restored the woman to a state

of comfort and usefulness. I would like to state here that as time goes on I am much less disposed to sacrifice the ovaries than formerly. Even a part of the ovary left in the abdomen is better than none; for while their existence may not enable the woman to bear a child, it prevents the occurrence of a premature menopause. And I believe the woman, especially if she be married, is happier and more content.

However, where the ovulation or menstruation is attended with great suffering in other parts of the body, such as severe headaches, epileptic attacks, and great prostration and despondency, the grave question will arise whether the menopause should be prematurely established by the ablation of the ovaries or not. Each case must be judged on its merits after a full understanding of all the facts; and the patient, or those who are responsible for her, should be informed of the nature and effect of the proposed operation, its risks, and its possible and probable effects. Thus far I have found the ablation of the ovaries for the cure of neurotic affections and mental disorders uncertain, and on the whole unsatisfactory; but in desperate cases one may be warranted in using desperate remedies.

The case of enterectomy of the ascending colon is an illustration of the possibilities of intestinal surgery. The patient was forty-five years of age, and had always fair health, although not a robust woman. She had suffered for several months from pain in the right iliac region, from constipation, and failure of general health.

Upon examination, a mass was found in the region of the ileo-cecal valve the size of a hen's egg, movable, but sensitive on pressure.

An exploratory incision was made just inside the crest of the ileum, and the enlargement was found to be due to cancer of the ascending colon, about an inch above the ileo-cecal valve.

The meso-colon was carefully ligated in sections, and the vermiform appendix, an inch of the small intestine, the ileo-cecal valve, together with about five inches of the ascending colon, were removed, and the end of the small intestine secured to the ascending colon with a Murphy button. A gauze drain was used for three weeks, the patient making an uneventful recovery. It is yet too soon to say that a permanent cure will result, but in the meantime her health is restored, and she is able to attend to her household duties.





