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Extirpation of the Uterus in Disease of the Adnexa

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REPRINTED FROM
THE AMERICAN JOURNAL OF OBSTETRICS
Vol. XXX., No. 1, 1894.

NEW YORK
WILLIAM WOOD & COMPANY, PUBLISHERS
1894

EXTIRPATION OF THE UTERUS IN DISEASE OF THE ADNEXA.[1]

THE questions involved in this subject are not many and may, I think, readily be determined. As in all other matters, when the agitation of the subject first began many of the points were obscured for the want of practical experience on which to base observation. This objection has now in great part disappeared, and practice has fully borne out what was at first anticipated and predicted from a partially theoretical standpoint. The discussion of the extirpation of the uterus in disease of the adnexa will be confined principally to the pelvic inflammatory diseases, other conditions being considered secondarily, for the reason that this procedure will be called for mostly in the former class of affections.

Certain general considerations arise in this connection.

Is the uterus essential or useful after the ovaries have been removed? If not,

1. Are all patients cured after an operation requiring double ovariotomy?

2. Are patients cured after hysterectomy, when double ovariotomy has failed?

3. Does the operation of hysterectomy increase the mortality above that of double ovariotomy?

4. Is the retention of the uterus of any disadvantage or danger to the patient?

Is the uterus essential or useful after the ovaries have been removed?—The uterus has one use in the body: that of containing and developing the human embryo. In the face of the loss of both ovaries it seems superfluous to argue that the further necessity for this organ has departed, and together with the

[1] Read before the American Gynecological Society, May, 1894.

necessity its usefulness. It is not true, as has been held, that the womb has anything to do with those peculiarities which go to make up the womanhood of the woman ; this rests solely in the ovaries. Nor is it a demonstrable fact that this organ has anything whatever to do with the integrity or support of the vaginal vault. If any support obtains to the vagina from above it is from the broad ligaments, but their integrity is destroyed by the double ovariotomy. As far as the cervix being the keystone to the vagina is concerned, there is no necessity for the removal of this structure ; the uterus may be extirpated by an amputation so low down as to be practically a complete removal and yet leave the vaginal portion of the cervix intact. Thus the relation of the vagina and cervix remains unchanged, and the pelvic floor with its attachments is relieved of the weight imposed upon them by a useless and probably diseased uterus. My own experience teaches that there is less sagging of the pelvic floor in those cases in which the uterus has been removed than in those in which simply a double ovariotomy has been performed.

This question being satisfactorily disposed of,

1. *Are all patients cured after an operation requiring double ovariotomy?*—The proposition is answered in the negative by a common and universal experience. There is no gynecologist who is not familiar with the patient who after a double ovariotomy returns month after month suffering with pain, metrorrhagia, or discharges of muco-purulent matter from the uterus. The subject requires no elaborate discussion, and the conclusion will with little doubt be conceded by all.

2. *Are patients cured after hysterectomy, when double ovariotomy has failed?*—Experience alone can provide the answer. Any amount of theorizing on the part of those who have not tried the method can have little weight as against actual facts. In my paper read before the Philadelphia Obstetrical Society, October 5th, 1893, two cases are reported in which the uterus had been removed subsequent to a simple extirpation of the appendages. After the primary operation these patients had continued to suffer from leucorrheal discharges, bleeding, and pain. The secondary operations for removal of the uteri proved that the appendages had been thoroughly and completely extirpated at the first operation and that no such cause as incomplete removal existed to account for the continued suffering. The

removal of the uterus in both cases cured the patients, and at the present writing they both remain in good health. Two other similar operations have been performed since that time with like results.

It is contended that proper uterine treatment will bring about the cure without the necessity of removing the womb. Many attempts have been made in this direction, with failure in many instances. The methods adopted have been local applications (intravaginal and intrauterine), and curettage with gauze packing of the uterine cavity. The first patient upon whom hysterectomy was performed in pursuance of this plan had been submitted to the primary operation of double ovariotomy a year or more previously, and the second operation was only undertaken after we were both worn out and disgusted with the lack of results from local treatment.

3. *Does the operation of hysterectomy increase the mortality above that of double ovariotomy?*—No fair comparison can be made of the work of any two men in different operations, therefore this query must be answered from my own work. In the paper to which reference has already been made, eight cases are reported upon whom this operation had been performed. Fourteen additional ones may now be included, making in all twenty-two operations. Of this number all recovered from the operation and the great majority have been cured. My highest mortality in the past has always followed removal of the appendages in this same class of patients. At no time have I been able to pick out anything like twenty-two successive successful double ovariotomies in cases of the same character as those upon whom I have found it advisable to perform hysterectomy. Not only has hysterectomy in my hands lessened the mortality very markedly, but it has rendered the convalescence infinitely smoother, easier, and more satisfactory.

4. *Is the retention of the uterus of any disadvantage or danger to the patient?*—Not infrequently the womb bleeds and gives rise to muco-purulent discharges indefinitely after removal of the appendages. If it be argued that in a proportion of such cases the removal of the appendages has not been sufficiently complete, one reason has at once been advanced in favor of hysterectomy; for, if this operation be the one of choice, there can be no such result as incomplete removal, as there at times of necessity occurs in the simple removal of the appen-

dages. If, on the other hand, these symptoms can be cured by the removal of the uterus, then there is at once an additional and unanswerable reason established for the performance of the hysterectomy. That these symptoms can at times be so cured, at least in certain cases, has been proven by the facts already quoted from my own work, as well as by the experience of other surgeons. The fact that the pelvic floor is more apt to sink to a lower level after the removal of the appendages than after a hysterectomy—a fact which has been observed by other surgeons as well as by myself—is a further argument in favor of the complete operation.

It is contended that about twenty per cent of all cases of pus tubes are of tubercular origin. It is also well known that it is, in a large proportion of such cases, impossible to decide this question at the time of the operation by the gross appearance of the parts concerned. Would any surgeon wish to leave the uterus in any case of known tubercular disease of the appendages, in the face of the large proportion of uteri which are known to be infected in such cases? It would seem that this was an additional strong reason for the hysterectomy.

The elimination of any fear of future malignancy in the uterus is by no means a small consideration.

These questions being all settled in the affirmative, it follows as a matter of course that hysterectomy is the operation of choice over double ovariotomy in a certain percentage of the class of cases under consideration. It remains, then, to determine in what cases to choose this operation.

It is well known that in pelvic inflammation the disease first affects the mucous membrane lining the womb, and secondarily invades the Fallopian tubes and the pelvic peritoneum. In many cases not only is the endometrium affected, but the inflammatory products invade the deeper structures which go to make up the uterine walls. These infiltrates undergo the same changes as do the same elements in the walls of the Fallopian tubes, whether it be suppuration or partial organization; in either case the process is apt to become a permanent one. The ease with which a ligature cuts through uterine tissue when applied at the cornua in cases of pus tubes, and the large, hard uteri so often found in conjunction with chronic interstitial salpingitis, are well-known demonstrations of the truth of this.

With Fallopian tubes and uterus, both of which are diseased

by the same factor and to the same extent, is it reasonable to suppose that a cure is to always be obtained by the removal of the tubes alone? Is it not rational to remove the whole of the disease, and not only a part? Theory and practice both combine in this matter to force the conclusion.

It must not be understood that the removal of the uterus together with the Fallopian tubes and ovaries is recommended in all cases of pelvic inflammatory disease. I am forced to dissent at this point from the views of some other surgeons with whose opinions in other respects I am thoroughly in accord. In many cases the uterus, possibly on account of its anatomical relations which are so favorable to good drainage, has succeeded in throwing off the original infection and is comparatively healthy, if not entirely so. Under such circumstances hysterectomy is not indicated. But where an abdominal section has been performed for the removal of the uterine appendages, and the womb is found enlarged and diseased, especially if it has been surrounded by extensive adhesions, the destruction of which leaves large areas of denuded peritoneum, hysterectomy should be the operation of choice. Even when the uterus is not greatly diseased, if during the course of the operation it be largely denuded of its peritoneal covering, it is best to complete the operation by its removal. The sole objection which could be urged against this procedure is an increased mortality; but, since this has been proven fallacious, opposition from any standpoint must necessarily be withdrawn.

It is freely granted that in accepting this practice uteri will often be removed which might safely have been left behind. Even in the face of this possibility the procedure is fully justified, in view of the possibility of future harm on the one hand and the certainty of no extra risks on the other.

The decision *pro* or *con* is at times a difficult one at the operation, in which case the patient should be given the benefit of the doubt and the uterus should be removed.

The same principles which obtain in this class of cases hold good in all other diseases when it has been decided that both ovaries must be removed.

Where the womb itself is greatly enlarged, infiltrated, or diseased, it is a proper subject for removal.

Where there is any good reason for believing that this organ

will in future become the seat of disease, it may with propriety be extirpated.

Where its removal will facilitate an operation or give greater security against hemorrhage, it is justifiable to extirpate the organ.

In all cases it is, of course, assumed that both ovaries must of necessity be sacrificed. Except in the presence of malignant or tubercular disease, the womb should never be disturbed if even a portion of one ovary and a Fallopian tube can be preserved. Nor is an operation to be extended to the performance of hysterectomy, where the double ovariotomy will even temporarily answer the purpose, should the patient be in such condition that the prolonged manipulation might render the result of a given case doubtful. Common sense must be used in the application of this principle, as in all other surgical procedures.

Hysterectomy being determined upon, especially in pelvic inflammatory cases, how should the operation be performed?

French surgeons have for some time been removing the uterus by way of the vagina. In doing so no effort has been made to remove the appendages, this being purely a secondary consideration; as a matter of fact it would be highly dangerous in some cases to attempt their removal by this source. In America, with rare exceptions, the abdominal method has been the one of choice, and is to be preferred for the reasons:

1. That all the parts may be exposed to the eye as well as to the touch, and hence greater accuracy and security obtained.

2. All intestinal injuries may be readily discovered and corrected.

3. The adnexa may be completely removed together with the womb (a very great desideratum).

4. All wounds may be closed, denuded surfaces often covered over with peritoneum, and in many cases drainage avoided. American operators have kept the mortality by this method as low or even lower than the French surgeons have by the vaginal method, with the additional advantage of making a complete removal of diseased structures, and are therefore more secure in the chances of better results. The only possible condition in which vaginal hysterectomy may be preferable is in those cases where there is a large pelvic abscess accompanied with dense and extensive intestinal adhesions, which it would be impossible or highly dangerous to the intestines to separate.

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