Gilliam (D. T.)

[Reprinted from the American Gynæcological and Obstetrical Journal for August, 1895.]

THE VAGINAL ROUTE FOR OPERATIONS ON THE PELVIC VISCERA.*

By D. Tod Gilliam, M. D., Columbus, Ohio.

It is not many years since all, or nearly all, operations on the supravaginal pelvic structures were done *per vaginam.*

In this category were operations for the removal of the submucous uterine fibroid, the evacuation of pelvic abscesses, hæmatoma, and other fluid collections, and later those for ectopic gestation. Following this came the craze for abdominal section.

The peritoneal cavity, so long the hobgoblin of surgeons, could now, thanks to aseptic methods, be invaded with comparative impunity. This gave a wonderful zest to the work, and it was prosecuted vigorously along all the lines. A flood of light followed the knife into the abdomen and pelvis, mooted questions were set at rest, false theories abandoned, and pathology revolutionized.

Brilliant surgical achievements followed each other in bewildering profusion, and the infatuation spread. The knife was in every hand, and many women carried on the most prominent part of their anatomy the private mark of their favorite surgeon.

At this time the gynæcologist who was not an abdominal surgeon was clearly in disfavor. Did he attempt to remove a submucous fibroid, eliminate the uterine appendages, tap a pelvic abscess, or in any manner deign to interfere surgically with supravaginal structures through the vagina, he was ridiculed and characterized as a fossil. This more especially among English-speaking peoples. Meanwhile the Germans devised and perfected a technique for vaginal hysterectomy which slowly but surely made its way into general favor.

One of the cardinal rules governing the selection of cases for this operation was that the uterus should be freely movable—so movable, indeed, as to be easily drawn down to the vulva. An attempt to oper-

* Read before the Ohio State Medical Society, May 16, 1895.

ate under other circumstances was regarded as reprehensible. Péan then conceived the idea of removing the immovable uterus. It was a bold thought and well worthy the genius of the great French surgeon. He succeeded. His success was the signal for a storm of antagonism. The operation was denounced as a wanton and wicked mutilation. To remove the womb for pelvic inflammation was treason to all the better instincts of humanity. "If," say they, "we remove the tubes and ovaries, open and drain abscess cavities, curette, cauterize, and pack the uterus, we have done all that is justifiable. Then, again, the mortality of Péan's operation must be appalling. Péan, it is true, with his marvelous skill, may meet with a measure of success, but the operation is not feasible and will die with him."

Péan replies: "A womb without tubes or ovaries is of no value. From it emanates poison that permeates and disrupts the pelvic structures. The Tait operation and curettage can not remove the trouble." A portion of the tube remains. It is infected. The ligatures that surround it are infected and the infection spreads again. The woman remains an invalid. Look at the anatomy of the parts. Observe how the blood-vessels and lymphatics center in and are distributed from the uterus. Observe, furthermore, how the natural drainage of the pelvis converges to the same point. If this organ be removed it will have the effect of removing a plug from the bottom of a basin. From a physiological standpoint the uterus is simply a nest for the reception and maturation of the egg—without appendages it is of no more account than a deserted bird's nest. From a pathological standpoint it is a hotbed of infection, distributing its deadly virus not only to the adjacent pelvic structures, but at times by way of the blood and lymph channels, scattering it broadcast through the general system. As a diseased organ in the midst of diseased tissues, it blocks the way to a free and natural drainage, and retards or renders futile Nature's efforts to eliminate peccant matter.

As to the mortality, I find that it is even less than the best results in the hands of the best abdominal surgeons. In time Péan was joined by Richelot, Ségond, Jacobs, and others, and, backed by such spirits the operation was lifted to such prominence as to demand favorable recognition.

Let us look a little further into its claims. General pelvic infiltration and multiple pelvic abscess as the result of sepsis has always been the bane of the abdominal surgeon. He knows when he meets such a case that he is to grapple with difficulties sometimes insuperable. He knows that he must reach tubes and ovaries and pus cavi-

ties through coils of agglutinated intestines and jumbled viscera. He knows that the adhesions are often dense, that the tissues are often soft and friable, and that rents in the bowel or bladder are likely to occur. He knows that the evacuated pus frequently inundates the peritoneal cavity and wells up through the incision ; that in draining he must drain against gravity. He knows that the immediate mortality is great, that convalescence is tedious with its loathsome accompaniment of discharging sinuses, that many cases never recover, but lapse into a state of hopeless invalidism. He knows that ventral hernia is almost a common sequence, that painful scars are even more so. He knows that the intrapelvic structures are often matted and disturbed in their relations, that intestinal embarrassment or obstruction is very frequent. He knows all this and much more. In the transvaginal operation the pelvic viscera other than the uterus and appendages are not disturbed. There is no handling of intestines, consequently but little shock. No breaking up of adhesions (except in so far as to liberate the uterus and appendages), no contamination of the peritonæum with purulent matter, but simply an elimination of irreparably diseased parts. These are taken from the central and under surface of the arch, and there is natural, free, and uninterrupted drainage. Under this all peccant matter is discharged, exudations absorbed, adhesions dissolved, resolution and restoration complete. The patient is well. The mortality is less than by any other method. There is no hernia, no painful scar, no sense of insecurity, no languishing to a long-hoped-for death.

Technique.—The instruments needed are a knife, two pairs of long-handled scissors slightly curved on the flat, three bullet forceps, a set of Péan's retractors, four broad-ligament and several hæmostatic forceps. The retractors being introduced, the cervix is seized with bu let forceps and a semicircular incision made in front from side to side, being careful to avoid the vesical wall. A similar incision is made behind but not so close to the cervix. From the junction of these incisions a linear incision three fourths of an inch in length is carried outward on either side along the face of the broad ligament. This imparts greater mobility to the uterus, and increases the distance between it and the ureters. With finger and scissors the cervix is freed from the bladder, a retractor being inserted into the opening and materially facilitating the process.

In like manner the cervix is freed behind. Forceps are now applied to the broad ligament on either side so as to include the uterine arteries, and the portion thus secured cut through, keeping close to

the uterine wall. The side retractors may now be dispensed with, the forceps taking their place. The cervix is next split up on either side, and the posterior half amputated. The anterior half is also amputated, but before complete severance a new hold must be taken by the forceps on the anterior uterine wall above. From this time on the operation consists in dissecting off the bladder, splitting the anterior uterine wall longitudinally in the middle line, seizing the same on either side and cutting it away piece by piece until it is destroyed and the fundus reached.

The anterior retractor should continually follow the finger into the depths of the dissection, and the traction forceps should always secure a new hold on the tissues above before a piece is cut away. When the peritoneal cavity is reached the narrow retractor should be substituted for the anterior one, and should be pushed up into the cavity. Traction on the fundus will now cause it to roll forward and out into the vagina. Forceps are now applied to the upper half of the broad ligament from above downward, and the uterus cut away. Should it be practicable, the annexæ are removed at the same time ; otherwise they may be left. Pus deposits, whether in the tubes or elsewhere, are opened, washed out, and drained, care being taken to protect uninfected parts by gauze packing. Adhesions to the uterus can usually be separated under the eye after its inversion into the vagina. A pad of iodoform gauze is placed over the tips of the forceps, to protect the intestines from injurious pressure, and between the forceps and vaginal walls, to protect the latter. The forceps are removed at the end of forty-eight hours, and after gentle irrigation the dressing replaced. The gauze pads above the vaginal vault are not removed for six days.

Notwithstanding the manifold advantages of the vaginal operation, as detailed above, it is not, as I believe, applicable to all forms of pelvic inflammation or all degrees of the same. There are limitations to its range of usefulness, as also its feasibility. For some years, under the domination of a passion for salpingectomy, every tube that could be made out to have undergone any pathological change was condemned to the knife. As a result there was a woeful and wanton unsexing of women, to the incalculable detriment of society. For the last two or three years we have been gradually coming back to our senses, and we find that under favorable conditions many of these ailments pass away entirely, while very few indeed pass on to a condition absolutely demanding operative interference or the sacrifice of the appendages. I do not think it proper, therefore, to remove the

annexa in many instances, and certainly not to remove the uterus except in the most aggravated cases. The danger is that this, like all other popular movements, will be carried to extremes; and in the eager chase for notoriety, and ofttimes through self-imposed blindness, there will ensue such a rage for vaginal hysterectomy as will do irreparable damage.

It was the dread of multiple pelvic abscess, the fearful mortality attending the operation for the same, and the very unsatisfactory results ensuing, that impelled the cœliotomist to attack the diseased appendages at an early period, in order to forestall such dire consequences.

It is in this connection that the great value of the Péan operation is manifested.

Relative to this, it may be said that the cœliotomist's extremity is the vaginal surgeon's opportunity. In other words, when the destructive changes of pelvic inflammation have gone to such an extent as to be practically beyond the reach of the cœliotomist, Péan steps in and, by removing the uterus *per vaginam*, makes possible a perfect recovery. Knowing this, the conscientious surgeon will keep hands off. As a result, thousands of women who have hitherto been sacrificed to the misguided zeal of the surgeon will resume the functions of life and maternity, and tens of thousands of children elsewise unborn will add to the strength of nations.