

BALDY (J.M.)

Removal of the uterus x x x



BALDY (J.M.)

[Reprinted from the AMERICAN GYNÆCOLOGICAL AND OBSTETRICAL JOURNAL
for January, 1895.]

REMOVAL OF THE UTERUS AND ANNEXA FOR PUERPERAL SEPSIS.*

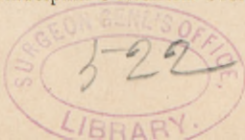
BY J. M. BALDY, M. D.

Surgical procedures upon the puerperal woman have not until recent years received any considerable encouragement, especially in that class of women who are suffering from acute sepsis. Since, however, a reluctant profession has come to recognize in the vast bulk of cases the local and true cause of puerperal fevers much has been done to obliterate past prejudices in this matter.

During February of 1887 I attended a patient, who presented the following history :

On the second or third day after confinement she had a chill with a quick rise of pulse and temperature, and a tympanitic and tender abdomen. These symptoms abated somewhat and I lost sight of her for several weeks. One month from the date of her confinement I was again summoned to her and found that she had been suffering since I had last seen her. She was at this time so emaciated that I hardly recognized her as my former patient. Her temperature was over 102° , her pulse over 130; she was having continued chills and creeps, hectic, night-sweats, and sleepless nights; her abdomen was swollen, tympanitic, and intensely painful, her bowels loose and fœtid, micturition and defecation both painful—she was evidently fast approaching death. An examination of the soft parts showed no signs of a recent tear; the uterus was subinvolved, and on the left side there was a large boggy mass, firmly adherent, tortuous, and extremely tender. The right side was tender but no mass could be detected. Abdominal section was advised as the only hope of saving life, and the proposition was eagerly accepted by both the patient and her friends. At the operation the left tube and ovary were both found adherent and distended with pus and were removed. The patient made a speedy and thorough convalescence.

* Read before the Philadelphia Obstetrical Society, December 6, 1894.



Schröder had held that septic endometritis did not extend to the tubes, *as a rule*; but he qualified this opinion by following it up closely with the remark that occasionally the endometritis did go on to a purulent salpingitis.

Tait and Sängér held much the same views, and the latter in an open letter to Tait stated that "salpingitis septica, co-existing with severe puerperal septicæmia, has never as yet given the surgeon an opportunity to remove the principal focus of disease by extirpation of the tubes. It is possible, however, that under certain circumstances such a procedure might be indicated."

Even before these words of Sängér's were in print I had found the opportunity in the case of my patient just quoted and had taken advantage of it. The case was reported in full to the Philadelphia County Medical Society, June 22, 1887, and is the first on record of which I have knowledge.

The report of the case opened up a wide field, and within a year a number of such operations were recorded. The subsequent work and investigation in this direction have brought us to the present practice, which may, I think, be stated dogmatically: *Whenever an ovary or Fallopian tube is found distended with pus in the puerperal woman the offending organ should be removed at once by abdominal section.*

In making this statement I am giving careful consideration to catheterization of the Fallopian tubes, curettement and gauze packing of the uterus, vaginal or rectal incision and drainage, and all other so-called methods of conservatism. Even when there is imminent danger of rupture into the rectum I prefer the section, as personally I consider a rectal opening a great disaster, and to be anticipated and prevented by prompt surgical aid.

It is useless for me to again go over the same ground so often covered in this matter—suffice it to say that I base my practice in the matter on the theory that where there is pus, it *must* be evacuated, and that it is much safer in the largest proportion of cases to evacuate it at a point of election than to allow it to empty itself, with all the chances of immediate danger to life as well as remote consequences.

There is one other point I would wish to impress most emphatically in regard to the "waiting policy" on the supposition that the patient can be "built up and prepared for the operation." In such cases this is rank nonsense. The patient is approaching the point where there is imminent danger to her life—the cause being the absorption of septic matter into the general system. If there is any drug or combination of drugs which will successfully combat the condition

it is absolutely certain that surgery in these cases must end : but the physician who attempts to deceive himself that at the present time this millennium has been reached and acts on this supposition, will stand in the way of many of his patients' only chances for life.

So much for true pus cases ; but another and larger class remain in which there is infection of the Fallopian tube, the ovary and possibly the peritonæum without any formation of pus but with more or less decided tubal and ovarian disease, with peritoneal and connective-tissue exudate, easily demonstrable by a local examination. Clinically such cases are met with every day in varying shades of intensity, and the question of treatment must be settled by two conditions : First, the general condition of the patient ; second, the ability of the physician to determine whether or not suppuration has occurred.

In the diagnostic ability of the physician then rests the whole responsibility. It is impossible to be dogmatic on this subject, for the reason that there are so many exceptions which must be determined in the case of the individual patient and her peculiar conditions at the time. In general, however, it is safe to say that in an attack of puerperal salpingitis and pelvic peritonitis dependent thereupon, no pus being present, an immediate operation is not demanded. Further, in those cases in which it is doubtful whether or no pus be present, the general condition of the patient permitting, I should prefer to delay, watching my patient closely and if necessary perform a secondary operation later on.

A third class is found among those who suffer from puerperal fever without any local signs of intraperitoneal inflammation as demonstrated by enlarged, thickened appendages, and inflammatory exudates. In other words those patients who are suffering from septicæmia due to the absorption of septic material from the uterine cavity and who are in imminent danger of dying therefrom. This class of patients is not small and will be found to grow in importance surgically the more closely they are studied. Beyond question there are a certain number of these women who will inevitably die unless the source of the absorption is cut off : a certain proportion may be saved if operated upon in time.

The only proper procedure under these circumstances is removal of the uterus, by which means the absorption of sepsis is at once stopped and unless sufficient has already been absorbed to too greatly disorganize the blood the patient will easily survive.

In making this statement I am aware that I am treading upon

comparatively new ground—ground which has not as yet been fully tilled but which is well under way in that direction. I am also fully aware of the fact that in advising such a radical step one is in danger of enticing many men into doing many unnecessary operations; but that I conceive is a matter for the conscience of each operator in each given case—one can only discuss these matters from their scientific standpoint. The stumbling block with which we are brought face to face in these cases is the ability of each one of us to determine which cases are suitable for operation—in other words which cases are likely to die from the septicæmia if nothing surgical is attempted. Further the amount of success to be attained will be directly dependent upon the period of the disease at which the operation is performed—like all other operations in acute diseases threatening life, the earlier the operation the more likely a successful result. It is evident that a wide range is left, and must necessarily be left, for individual judgment, based on the condition and symptoms of the patient and unless great care be exercised much unnecessary surgical interference may take place.

A discussion of the symptoms and diagnosis does not come in the province of this part of the subject.

My own belief in the matter is that hysterectomy for this class of patients is of limited necessity, excepting in cases seen in consultation. In other words I believe that in the vast majority of septic cases seen in time, dangerous complications can be avoided by thorough curettement, irrigation and antiseptic packing. In consultation however for obvious reasons we are bound to see cases in which even this procedure, repeated, will not lead to good results. These are the cases in which hysterectomy must be considered.

A sufficient number of such operations have been performed to demonstrate its entire feasibility. By members of our own Society four successful cases at least have been achieved. Howard Kelly removed a septic uterus from a dying woman five days after infection and saved her life. Barton Hirst removed a septic uterus one month after confinement with a successful issue and has recently removed another one ten days after infection with an equally favorable issue. E. P. Davis removed a suppurating uterus two weeks after infection with similar results.

I know of several unrecorded cases of fatal issue but in each case I am convinced the operation was postponed too long.

To conclude, and speaking dogmatically. Patients suffering from puerperal septicæmia with pus in the appendages should be submitted

to an abdominal section. If the pus be contained in one Fallopian tube or ovary, only that organ should be removed. Should it become necessary to remove both appendages, the general condition of the patient permitting, the uterus should be removed at the same time.

It is well in patients suffering with puerperal septicæmia in whose case suppuration has not taken place and in doubtful cases, not to operate, the general condition of the patient offering no contra-indication, but to await and allow the subsequent course of the symptoms decide as to the proper treatment.

Patients suffering from puerperal septicæmia due to absorption of septic matter from the cavity of the uterus whose lives are seriously threatened will in carefully selected cases demand early hysterectomy.

Since writing this paper a multipara who had had a miscarriage a week ago came into my hands for treatment. Since her miscarriage (at the second month) she has been suffering from chills and fever with tender and swollen abdomen. A vaginal examination disclosed a large soft uterus, bleeding, with a purulent discharge from its cavity; the appendages were enlarged, fixed and boggy. This morning I opened her abdomen and removed both ovaries, Fallopian tubes and uterus. The tubes contained pus, the uterus was large soft and friable, the ovaries large, soft and apparently about to break down. There was an abscess in the pelvis at the junction of the fimbriated end of the left Fallopian tube the ovary and the lower part of the pelvic wall. She left the operating table in good condition. I will report the result at another meeting; at present I see no reason why she should not recover.

This makes the fifth case reported by members of this Society: Hirst, 2. Kelly, 1. Davis, 1. Baldy, 1.

