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INCIPIENT UTERINE CARCINOMA.

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presented by the author

INCIPIENT UTERINE CARCINOMA.[1]

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A striking instance that came to my notice only five days ago, of what I am inclined to designate as either a case of indefensible negligence or ignorance on the part of the medical attendant,—probably the latter,—impels me to bring to your consideration to-night a subject, than which none more important exists in gynecologic practice, or even in the entire domain of surgery itself. I refer to the recognition of incipient uterine carcinoma.

In November last there applied to me for relief a woman, 44 years of age, married twenty-six years, and the mother of seven children, two of them premature. She had enjoyed excellent health until within the past few months, when she commenced to suffer with uterine hemorrhages, not confined to the menstrual epochs, and steadily increasing in severity until they would last for three weeks at a time; in the intervals they were accompanied by a leucorrhea which was at times offensive. She was a devotee of homeopathy, but had come to me upon the recommendation of a friend whom I had confined a few months before. Suspecting malignant disease from the history presented, taken in association with the age of the patient, I instituted a vaginal examination and elicited the following points: The perineum and cervix were lacerated, the os was patulous and much eroded, and the fundus uteri was anterior, although the organ was situated low in the pelvis. The patient informed me that she was steadily losing in flesh; that she was very much constipated, and that she suffered from severe pain in the ovarian regions and in the small of the back.

From the facts thus obtained I felt justified in telling the woman that her condition was a serious one, and advised radical treatment, with the very common result of scaring her off. I did not see her again until last Saturday evening, when she sent for me for relief from pain. She then informed me that since her previous visit to me she had been under the care of her family physician, who had told

[1] Read before the Charles B. Penrose Gynecological Society of the University of Pennsylvania, April 16, 1896.

her that she was suffering from an inflammation of the ovary, and had treated her for that condition. I repeated my examination, found a well-marked carcinoma, confined, however, to uterine tissue, and again urged immediate extirpation of the diseased organ.

With this short summary of the facts of an interesting gynecologic case as a text, permit me to direct your attention for a few minutes to the methods at our disposal for recognizing this grave disease in the earliest stages,—at a time when prompt intervention at the hands of one experienced in pelvic surgery will offer the patient every chance of absolute recovery. In the first place, let me urge upon you the importance of training yourselves to be on the lookout for uterine carcinoma. The history of profuse hemorrhages at or shortly after the menopause should be as strongly suggestive to you of the possible existence of uterine carcinoma as is the history of menstrual suppression in a younger woman of the possible existence of gestation. I regret to say that the profession itself is largely responsible for fostering the idea so prevalent among the laity that the climacteric is characterized by profuse and irregular hemorrhages. No belief is more erroneous than this, nor does any lead to more disastrous conclusions. With this fallacious view strongly engrafted upon their minds, many women endure in silence hemorrhagic effusions that at another period of their lives would promptly demand active interference from their medical advisers, and thereby frequently permit the opportunity for absolute eradication of the disease. Hemorrhage at this period should be regarded as a most ominous sign of grave organic disease, and its cause investigated.

Neuman[1] has recently examined into the cause of post-climacteric hemorrhage from the genital tract in a series of 1000 cases collected in the Schauta clinic in Vienna. Of these cases, in more than half (55 per cent.) was the hemorrhage due to cervical carcinoma; in the remainder of the cases the bleeding resulted from erosion, ulceration, mucous polypi, sarcomatous degeneration of myomata, and carcinoma of the body. Neuman believes that when chronic and severe metrorrhagia occurs in a woman who has passed the menopause, and she is failing in health and becoming anemic, a diagnosis of carcinoma of the corpus uteri can be made almost with certainty, provided there does not exist carcinoma of the vaginal cervix. In making the diagnosis of corporeal carcinoma there are two procedures of great assistance that may be adopted,—namely, digital palpation of the uterine cavity after cervical dilatation, and a microscopic examination of the curetted tissue.

[1] Monatscheft für Geburtshülfe und Gynäkologie, Band 1, Heft 3, 95.

Kessler[1] has recently stated that while uterine carcinoma, if encountered in the early stage, can be cured by a radical operation, the mortality of which is only 5 per cent., as a matter of fact not over 15 per cent. of those thus treated survive, because the patients apply too late to be cured. He claims that statistics show that in the majority of the cases well-marked symptoms of the disease had been present for a year or more before the disease was recognized, and *that in 50 per cent. of these women the family physician failed to make a vaginal examination.* A most deplorable fact, if this statement be true, and we have every reason to believe that it is.

When confronted by such figures as these, Stone's suggestion[2] of a systematic vaginal examination at intervals of six, twelve, or eighteen months in all parous women between the ages of 40 and 50 years, while at first sight impracticable, would appear to be an absolutely justifiable procedure.

Given a case of suspected malignant disease of the cervix uteri, what are the features upon which may be based a presumptive diagnosis of incipient carcinoma? They are not many, but to an experienced eye and a close observer they are strongly suggestive. They will vary according as to whether the disease originate in the portio vaginalis or in the cervical canal, and as to whether it appear in the nodular form or as a mere superficial erosion of the surface. A very noteworthy feature in the nodular variety is the peculiar angry appearance of the elevated area, which, while it may be differing but slightly in color from the adjacent healthy mucosa, bleeds freely upon the slightest touch, and is dense and resilient to the feel. Herman[3] considers a smooth, dark-red spot upon the cervix, bleeding upon contact, as a very suspicious symptom indicative of the earliest stage of carcinoma, the suspicion being stronger should a nodule be felt. The most characteristic feature of the hemorrhage is that it follows a trivial local irritation; thus, it is very common after coitus, or it may be profuse after even the most careful introduction of the speculum in a gynecologic examination. This tendency to hemorrhage is very suggestive.

It is not at all uncommon for the two conditions,—granular erosion of the cervix (the catarrhal patch of Penrose) and early carcinoma to be confounded. In both of these conditions the hemorrhage may occur with almost equal readiness on the slightest manipulation, but the malignant disease is characterized by a peculiar elevation and induration of the periphery of the affected area, which is very striking,

[1] St. Petersburger medicinische Wochenschrift, No. 37, 1895.
[2] Virginia Medical Monthly, Vol. XX, No. 12, 1894.
[3] British Medical Journal, May 12, 1894.

and which prevents the ready displacement of the mucosa upon the subjacent tissues, while the cancerous tissue within is exceedingly friable, cutting out easily. This is such a characteristic feature of malignancy that Sinclair [1] regards it as a clinical sign of exceptional value. He states that if the suspected area be exposed through a speculum, and scraped with a sharp spoon curette, it will simply bleed, or, at most, yield small shreds of tissue if non-malignant, while, if cancerous, the soft, cheesy nature of the diseased tissue will be readily recognized. The microscope will confirm the suspicion, but it must be remembered that an examination of the scrapings of the curette will not suffice. As Robb [2] has remarked, "It is possible to have an increase in the number and size of the (cervical) glands, and even the presence of more than one layer of epithelium, without any coexisting malignant disease." It is only when the subjacent tissue is involved in the process that an accurate diagnosis of carcinoma can be made, and this can be determined only by excising a portion of the deeply-lying tissues, either with or without cocain, being careful to include the margin of the healthy as well as a portion of the affected tissue. A microscopic examination of the removed tissue can then be made with a reasonable expectation of arriving at a positive knowledge of the condition. Should malignancy be discovered, an immediate extirpation is demanded, since this removal of a section is in reality a partial operation, and exposes the patient to the risk of a rapid spread of the disease to remote parts through the agency of the opened veins and lymphatics.

Other clinical manifestations of undoubted value in the early recognition of this disease are the characteristic sacral pain—a very common symptom—and the offensive and acrid leucorrhea, which may indeed be the primary manifestation of the disease, present long before other more positive changes may be noted. Such a leucorrhea in an elderly woman associated with irritation or excoriation of the parts, or with an uncontrollable pruritus, should excite apprehension as to a possible beginning malignant change, and should, at least, be an incentive for frequent and careful physical explorations of the cervix and corpus uteri to prevent a fatal oversight of the true condition. Associated with the foregoing symptoms must be noted a progressive loss of flesh and strength, and the clinical picture of early carcinoma of the uterus is complete.

[1] Medical Chronicle, 1875, No. 5.
[2] American Gynecological and Obstetrical Journal, New York, September, 1895.