REPORT OF A MIXED GROUP OF ABDOMINAL SECTIONS, WITH A DISCUSSION OF METHODS.

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My object in reporting a group of consecutive operations is to demonstrate, first, that gynecologic operations should be done for disease only; second, that if our simple tested methods are followed faithfully, and operations are completed, the mortality can be made uniformly low; third, that operations should not be delayed by the general practitioner.

It is of interest as well as of value to note, in an introductory way, what has been done, how it has been done, and what have been the results. Very much that is done now in abdominal surgery would not very many years ago have been regarded as criminal interference, and would have subjected the surgeon to civil or criminal prosecution. Now *not* to interfere would be construed by the advanced men of the profession, if not by the law, as gross ignorance or criminal neglect. These embarrassments and risks were faced by our few heroic pioneers, who did more, in facing and battering down the enmities and prejudices of the great body of the profession. The lines their hands drew we have followed, and have extended and broadened, but we have improved very little on what they did and the way in which they did it. When we run our eyes along the lengthened and lengthening lines of surgical progress we feel a profound sense of gratification, of debt and gratitude to men of our own and other generations who have contributed to this progress. We have learned and unlearned much. We have very much yet to learn and to unlearn. Our differences are interesting and instructive. The sum of the results of earnest effort by the members of a profession marks the progress of that science. But some men have presented real achievements, to be refused recognition for ages, but we also know and regret that our attention is far too easily diverted from its necessary sober train by some enthusiast or speculator in some wondrous field of remedy. In no branch of human science or endeavor are these enthusiasts, these lineal descendants of Plato, so numerous as in surgery. They would effect grand revolutions in a day. In illustration, we need only refer to Apostoli and his disciples. The electrolysis rage spread over two continents. Many educated and sincere men adopted this mode of treatment, and, sad to reflect, the sequelæ of the epidemic still linger with a few of the profession. For a time it was claimed that almost every known trouble could be cured by electrolysis: fibroids, extra-uterine pregnancy, retroversion and prolapse, and many other diseases. The mania had its day—it came and passed as those things do which are without rational basis, which cannot, do not, withstand practical, scientific tests. Comparatively few can now be found following Apostoli's methods. The majority of his disciples have laid aside the little machines in which they invested some of their surplus, and with which they toyed with the maladies of suffering women, aggravating troubles in many instances, or nursing delusions of relief and cure. This matter is more serious than we are disposed to consider it. Our voices are influential. Let us make sure of the value of what we do and the way in which we do it. Treatment by electricity furnishes only one of many instances of particular remedies or surgical procedures that fall short of their early promise, that do not permanently relieve or cure. The very names of the originators sink into obscurity or have only the unenviable distinction of being associated with an historic failure. Such experiments have a serious side. Many are the victims of delusive forms of scientific zeal. It is the patient who suffers, and not the experimenter. While it must be acknowledged that very much of our knowledge and our ability to treat and relieve human suffering has been the result of experiment, the experiments have been along legitimate channels, and by methods that entail no mischief. The tests are scientific. The motive of the experimenter should always be a purely scientific one, without the taint of any desire to associate his name with something new, to be an originator. It is not a fact that names record discoveries. There are names associated with surgical appliances and procedures that were in use before the claimants were born. Our science and art are made up of myriads of contributions, and it would be difficult to tell from whom they emanated. Use popularizes a discovery. Everything scientific or otherwise is tested by its utility, its facility of practical and successful use.

Generally, our departure from simple, easy, scientific and common-sense methods results in mischief. The varied and complex conditions with which we have to deal do not call so much for surgical genius as for surgical common sense. Skill and success in doing comes of doing. In surgery it is not safe to assume advanced theoretic positions on the mere faith that they will afterwards be confirmed. Such theories often lead to dangerous experimentation with human life.

In all surgical troubles, those that commonly possess minutiæ or detail should receive the closest attention. Little things become agencies working good or evil. Size often is given undue importance, while not infrequently it bears small relation to the seriousness of the trouble. The very minute may be the very dangerous. There should be special study of the pathology of intraperitoneal and pelvic disease, with a long apprenticeship in dispensary service. Where opportunities exist for careful study in the diagnosis of pelvic troubles, such diagnostic skill should always be attained before there is any attempt made in the surgical treatment of abdominal troubles.

In presenting a mixed group of operations, selecting from a series each of a hundred, about every known and established procedure was called into practice. At the present time, sections for suppurating forms of disease are most common in excess of all others; fibroids and cystoma

follow, and following in very close order come tubal pregnancy and appendicitis.

Surgeons are largely influenced in their methods of operation by their fancy and their ability to apply and perfect them. They resort to those in which they are the most deft in use, which bring them the best results. Many procedures had a short life; for instance, the tying of the broad ligaments and their vessels.

In surgery, as in other things, we coin from our experiences our best lessons. My earlier experiences and my later one have confirmed in me my conviction of the importance of drainage. It has had its advocates, and those denying its value, those indifferent to its use; and not a small number claimed that its use was evidence of imperfect, incomplete or bad surgery. Just now it would seem that all are drifting to its use. Those who were loudest in their condemnation of drainage are now loudest in its advocacy. Nothing so quickly drives men to the use of an expedient as failure without it. A few or many deaths set men down to sober reasoning; if not, patients and their friends will do the reasoning for them.

It has been claimed that drainage is not necessary in "ordinary" cases, owing to the absorbent power of the peritoneum to remove sections. It requires more prescience than any of us possess to decide in many cases that the peritoneum will rid its cavity of the exuded fluids from broken-up adhesions. If the tube has no injurious effect, it is better to use it in every case than to risk non-absorption in a single case, which may have been thought to be "ordinary," but which has turned out the reverse. The question resolves itself into distinct propositions: First—Is there any danger from the retention of fluids in the peritoneal cavity? Second—Is the use of the drainage-tube a safe means of obviating these dangers? If the tube involves in its use an element of danger, what are the comparative dangers from its employment or its omission? That the peritoneum will, in many cases, relieve itself of exuded fluids, may be accepted as true. Experience has also shown that when it refuses to do so unaided, the free use of salines often assists it, and cuts short an acute attack of peritonitis. Experience has also shown that this mode of treatment often fails, necessitating the re-opening of the abdomen, thorough irrigation and the secondary use of a drainage-tube, even though no pus has been discovered on the re-opening.

The fallacy in supposing an operation simple because no great adhesions have been involved, lies in the fact that great secretion can arise from small adhesion, and that exudation of blood, which seems nothing at the close of the operation, may, when the patient rallies from the shock of ether and of the operation, become very considerable. Does the use of the tube involve a question of danger? My answer is, were half the care used to keep the tube carefully cleaned, and to protect it from external contamination that characterizes the Gatling-gun warfare against germs supposed to enter through it, there would be little cause to fear it. If the tube is kept clean, if it is emptied often, it should be removed by degrees, commencing as soon as the discharge seems to be at a minimum, and in most cases no more irritation will be caused by it, or with it, than some inadvertance will explain. When an entire pelvis can be packed with lint to subdue hemorrhage, is it possible that a simple glass tube can cause such trouble as is frequently attributed to it? As to the use of the tube, my own experience teaches me that when kept clean, by frequently changing the cotton, and with careful attention to that part of the incision through which the tube is introduced, there is not the slightest danger of septic infection from its use.

This conclusion is reached after its application in extreme cases of pelvic adhesion, extra-uterine pregnancy, hysterectomy, pus-tubes, and (so-called) simple operations. I have never had a single case in which I could justly attribute unfavorable results to the use of the tube. On the contrary, I have seen more than one case in which its absence has been followed by mischief, which was relieved by its introduction. I have seen cases, too, in which I believe failure was due to its omission. Concomitant with drainage comes its adjunct irrigation. It is of the greatest possible use to insure complete removal of *debris*, clots and shreds.

As to the use of solutions, they have fortunately had their day. Much of the intestinal mischief, for which they were responsible, will go unrecorded. As to the time for removal of the tube, nothing should influence this more than the nature and quantity of the discharge. When this is clear, sweet and scant, the indications are for removal. It has been held that the introduction of the tube delays union, and increases the danger of ventral hernia. This my own experience discredits. Ventral hernia, I believe, in most cases, results from two causes: First, a very long incision; and second, getting up too soon and abandoning the abdominal support too early.

A short incision, and due care to keep the patient in bed and at rest, a sufficient time for the margins of the incision to organize and consolidate together with abdominal support through a period of months, obviate this trouble.

There is much mischief worked by the use of certain words. They have a vicious significance for students and beginners. Among them are such as "hopeless," "inoperable." They express surgical cowardice, and are responsible for the death, or long-continued suffering of many noble women, who could be relieved of their suffering and their lives spared. They are words certainly not entitled to place in our surgical vocabulary.

The spirit should be all abroad in the profession to go at our work, uninfluenced by self, with the highest courage and the deep persuasion that it is duty to relieve suffering and save life at any and every cost, and not to hesitate or stop until the work is done, and completely done. If this is ideal, then he becomes the better surgeon who sets it up as such, and reaches for it. We cannot save all, but we can save more than we do by less hesitancy, greater promptness, more directness and thoroughness, and through better studied and more carefully applied surgical art.

As to the justification of certain operations there will always be a wide difference of opinion. In this relation we will take the opinion of those who, by their experience, have a just claim to speak.

As to the uterine growths or fibroids, so violently at one time did the discussion rage that the doors of professional courtesy were closed upon the advocates of the operation; and in 1872 a committee of the Academy of Medicine of Paris condemned the procedure, reporting that "the extirpation of a uterine tumor is always a serious matter; the uncertainty that exists of completing the operation, the risk of fatal hemorrhage, the nervous shock, peritonitis, and secondary hemorrhage;" and they concluded by asserting that "the success obtained by some surgeons proved nothing."

The work of different operators differs widely in character. Some good operators absolutely refuse complicated operations; they do large numbers of ventral fixations and shortening of the round ligament (Alexander operation); they also practice incision and drainage, with a mortality higher than it should be in complete work, say four per cent., in vaginal incision and drainage for pus. All-around complete surgery, as given and practiced by the originators of our established procedures, would place us on a good and safe footing.

I have not lost a patient since October 16th, 1896. The one dying on that date had been ill for some years. The precise nature of the trouble—suppurating tubes and ovaries with adhesions extending as high up as the umbilicus—had been recognized by two or more attendants. The emaciation and enema were alarming, and complete suppression of urine followed the operation.