CORDIER (A.H.)

[Reprinted from the AMERICAN GYNÆCOLOGICAL AND OBSTETRICAL JOURNAL for August, 1896.]

THE VAGINAL *VS.* THE ABDOMINAL METHOD OF DEALING WITH INFLAMMATORY DISEASES OF THE PELVIS.*

BY A. H. CORDIER, M. D., KANSAS CITY, MO.,

Vice-President of the American Association of Obstetricians and Gynæcologists;
Professor of Abdominal Surgery Kansas City Medical College;
President of the Tri-State Medical Society, Etc.

The aim of the surgeon in the application of his methods is to obtain the maximum benefit with the minimum sacrifice of structures, the least amount of risk to life, and the saving of time and pain to his patient. These various results are best obtained by one surgeon by the following of a technique to him easy and successful, while another is equally successful in obtaining the same results by a procedure different wholly or in part. With many surgeons the choice of operative procedure determines his success, while others possess that rare gift of making a success of any and all methods, and are to be congratulated and admired by those of less dexterity. Some never make a success of any method, and are constantly scanning the pages of foreign literature for something new to try. In this way much harm is wrought to surgery, and many lives lost. I would not be misunderstood on this point, as I do not in the least desire to place a depreciative stamp on any good and safe surgery, be it foreign or a home procedure; but I do desire to enter a protest in the matter of hastily accepting the revival of a class of surgical procedures discarded some time ago in this country, and lately revived in part in Europe. I refer to the draining and partial removal of the diseased appendages, and the total removal of the uterus in cases of double tubal disease.

* Read before the Missouri State Medical Society at Sedalia, May 19, 1896.

COPYRIGHT, 1896, BY J. D. EMMET, M. D.

SURGEON GEN'L'S OFFICE. 560. LIBRARY.

That the reports from a few skilled operators are so favorable (in as far as concerns immediate recoveries) that they are seductive no one will doubt, and a temptation to accept the theories and follow in the footsteps of the advocates of these methods, on first reviewing, is often too strong to be resisted by many.

It is perfect surgery, or as nearly perfect surgery as is possible, that all surgeons desire, but, before accepting precepts involving human life or comfort, all evidence should be brought to bear on the topic, duly analyzed and weighed for its proper worth.

It is from this standpoint that the writer desires to discuss the subject of vaginal hystero-salpingo-oöphorectomy, as described and practiced by many of the French and a few of our American gynæcologists. Some men in other professions achieve renown by the mastership of their art; for instance, Paderewski, whose dexterous fingers and delicate touch on the ivory keys of his piano has startled and charmed the people of two hemispheres. However, there is but one Paderewski.

The limit and the character of the pathology should form an indication as to the character and the extent of the surgical procedure. A succulent and pus-infiltrated uterus, with possibly numerous pus foci, surrounded with pus-laden tubes and ovaries, should be removed, the choice of operative procedure being the one that, in the opinion of the surgeon, offers the greatest chances of immediate recovery from the operation, a permanent relief of the constitutional (septic) manifestations, the local symptoms resulting from the presence of these diseased structures, and the repairing of the damage to surrounding organs wrought by their presence.

A cancerous uterus should always be removed, if seen before the disease has extended to surrounding organs. The tubes and ovaries, as a rule, should be taken along with it, thus getting as far beyond the diseased area as possible.

A uterus known to be tuberculous should be removed along with the appendages, as by so doing a systemic infection may be averted. The cancerous and tuberculous uterus, as a rule, can be removed through the vagina, for, if the disease has advanced so far as to involve the viscera, the case is an inoperable one, and should be left alone so far as surgery is concerned. The operation that promises nothing more than a specimen and a fee is not within the domain of legitimate surgery.

In an old recurring puriform disease of the uterine annexa, where

the adhesions are well organized and where the intestinal bladder and omental attachments are firm, the vaginal method would be fraught with more danger than the abdominal. These cases have established in part a peritonitic immunity by a prolonged and gradual process of auto-sero-therapy; consequently, the abdominal method is not so liable to inaugurate an acute dangerous peritonitis or septicæmia, as is often the case in the acute or primary attacks if operated on.

Some of the advocates of the vaginal method only a short time ago maintained that it was an admission of incomplete operation to use drainage, yet they advance the good drainage by the vagina as an argument in favor of the vaginal route.

It has long been an established and demonstrable fact that, in the great majority of instances, the uterus is capable of taking care of itself, and that it does not give rise to any trouble by its presence after the diseased appendages have been removed. I do not understand why an organ with a good and free natural drainage should not recover, and yet (as is claimed) an ovarian abscess or parts of diseased tubes, with walls as thick and as shaggy as a cocoanut, get well with only an opening into the vagina.

To remove the uterus and a part only (as is admitted in many cases) of a diseased tube and ovary, and leave a filthy sequestrum in the pelvis, and expect Nature to cure the case, is not good surgery, and a larger percentage will be found to have imperfect recoveries, fistulæ, and continuance of the pain than if the work had been completed. This it is possible to do, and it is done by good surgery when operating suprapubically.

The Trendelenburg position and vision surgery took possession of the minds and technique of many operators a few years ago, and numerous articles were written lauding the advantages of that position while doing abdominal and pelvic surgery. The pathology is rarely confined to the pelvis, but its effect and extension are often found at the umbilical level. Some of these operators (and many of them are skilled and successful in every surgical sense) are now practicing and teaching the dark-route (vaginal) method, where strong instruments, the sense of touch, much muscle, and adhesive or staying qualities are factors in the make-up of the surgeon and his surgical outfit, and essential to getting the specimen or part of it.

The vaginal-route operation is not an easy one, neither is it as quickly performed as the suprapubic.

Pus is not always found in the tubes and ovaries where their removal is demanded. Firm and well-organized adhesions are often found binding the omentum, bladder, uterus, tubes, and ovaries firmly together. These adhesions were at one time Nature's breastworks thrown out for the protection of surrounding organs, but, like Nature's work in many other localities, she here fails to undo her imperfect work. The vascularity or limit of these adhesions is only determined at the time of the operation. An omental adhesion to the fundus may be torn across in the beginning of an operation, and scarcely a drop of blood escape, while in another the hæmorrhage may quickly prove fatal. A bleeding of this character is best controlled by a good ligature, such as it is only possible to apply in all cases correctly by the suprapubic method.

A prolapsed uterus surrounded by inflammatory diseased tubes and ovaries can best be treated by a vaginal hysterectomy, removing appendages at the same time. In this condition the uterus is not removed because of a fear that its infected state would preclude the possibility of a relief of the symptoms, but to relieve the symptoms induced by the procidentia. Some of these cases are cured by the removal of the appendages, a ventral fixation of the uterus, and a repair of the vaginal tears.

Occasionally a gynæcologist is called to see a case in the first attack, and finds the general state of the patient such that to attempt the major or curative operation would be fraught with a danger of such magnitude that it would be bad surgery to do otherwise than simply to make an incision into the mass in the vaginal vault and drain, with the idea of completing the operation at some future time. All are agreed upon the course to pursue in such a case.

If the case should prove to be a true pelvic abscess, one of those extremely rare cases in which the pus is extraperitoneal—or, in other words, between the layers of the broad ligament—this seemingly minor procedure will be found, in the majority of instances, all that is necessary to effect a cure. These cases are rarely met with in practice, and not so often in the literature of to-day as in that of former years. To remove the uterus in such a case would be a sacrifice unwarrantable, as there is nothing to be removed but the pus.

A failure to discriminate between this rare disease and the more common tubal disease until in the midst of a vaginal hysterectomy is extremely unfortunate, as it is then too late to retrace, while, if the

incision was made suprapubically, the error would not be so expensive, and the correct course to pursue would be pointed out.

It may be claimed that through a posterior vaginal opening the appendages can be examined, and the same deduction arrived at as though the abdomen was opened; but the fact must not be lost sight of that in these cases (true pelvic abscess) the pelvic peritonæum is clean and uninfected, and that a posterior opening endangers the safety of this structure. A safe rule to apply here would be to cut into the bulging part where the pus is nearest to the mucous membrane.

In the midst of a prolonged and difficult operation for the removal of the uterus and pus-bearing tubes an alarming hæmorrhage sets in, the exact source of which can not be found. The patient's abdomen is opened in the quickest possible time, with an imperfect asepsis, and the bleeding controlled; but three days later the patient dies from a peritonitis.

The operator can not take the necessary time and precaution in preparing his instruments, his patient, and himself to do a clean abdominal operation when the question of most importance is to quickly save his patient from hæmorrhage. The above remarks applicable to bleeding are of equal force in most instances where an intestine has been opened through the vagina. Very few operators, I am sure, would feel competent or able to put in a row of Lembert sutures, and make a closure of an intestinal rent that could be trusted to keep in liquids and gases.

The mesentery, in cases where many adhesions are present, will be found thickened and shortened at the time of operation to such an extent that it would be impossible to pull a coil of bowel down into the vaginal opening, already filled with a dozen, more or less, pressure forceps.

In comparing the relative ease with which the manipulation can be carried on through an abdominal incision and an opening in the vaginal vault, it must be remembered that the bony resistance met with by the impinging of the hand against the pubes is unyielding, differing very much from the pliant muscle of the abdomen under anæsthesia.

A small percentage of post-operative herniæ is found following in a large series of abdominal incisions, but these are discovered by the patient and not by the surgeon, and are not of such frequent occurrence as to be used as an argument against the suprapubic

incision. Time and close investigation of the vaginal cases will reveal an equal or a larger number of vaginal bowel protrusions.

The length of the mesentery precludes, in most instances, the possibility of the intestine reaching the outer entrance to the vagina, and many vaginal intestinal herniæ will not be discovered by the surgeon owing to the return of the bowel when the patient is in the usual position for vaginal examinations. In examining for a vaginal hernia, the examination should be made with the patient standing.

It is not sound argument to advance that the woman with a vaginal operation can get up and be about in ten days, as it is not probable that the vault has healed so much more quickly than a smaller, clean, incised wound in the abdominal walls.

One writer says: "The abdominal scar is a source of great worriment, especially to the Frenchwomen, who are great admirers of a fair complexion and unblemished skin." A suprapubic scar and a low-necked dress may be incompatible in Paris. Even some who held other views are made converts to this idea after visiting the French metropolis.

Very few cases in abdominal surgery die from shock if the work of the operator is decisive and quick. "Chronic surgery" and prolonged anæsthesia kill many patients, regardless of the character or location of the pathology or route of surgical approach. Septic patients endure anæsthetics and slow surgery badly.

One writer, and, by the way, a good operator, in praising the vaginal system, says: "Landau has done good work, but in a great many cases he *opens the abdomen to finish.*" (Italics mine.) Landau is regarded as an expert surgeon, yet in a large number of cases he is compelled, in the midst of an already prolonged vaginal operation, to open the abdomen to finish his work, thus making two incisions instead of one, opening the pelvic and abdominal cavities. This work can always be completed by the suprapubic route.

Not a week ago, in breaking up universal adhesions, the appendix (which was diseased) pulled off at its cæcal end, leaving a ragged opening into the cæcum. The discovery and closure of the bowel injury saved my patient. Others have had similar experiences.