Eastman (Jos.)

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FORTY CONSECUTIVE CASES

BY

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INDIANAPOLIS, IND.,

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VAGINAL EXTIRPATION OF THE UTERUS—FORTY CONSECUTIVE CASES.[1]

THE lines of sound surgical principles converge toward perfection of technique in operating and the ideal operation. The proximity to the ideality of an operation is in direct ratio to the simplicity of its technique and the results obtained. Ideal results are only secured by ideal operators, with ideal surroundings, with ideal atmospheric conditions, upon ideal patients. That no large number of patients could be found equally able to withstand the shock of a formidable operation is a fact well known to the surgeon. The other conditions can nearly always be secured. The great Dudley, of Kentucky, used to keep his patients under observation, and treat them with a view to bringing them up to the best standard attainable, and it is doubtful if his record has been equalled. "Knowledge comes, but wisdom lingers." So countless methods of performing ovariotomy have come and gone, while the operation as done by McDowell is in almost every particular identical with that made by the successful operator of to-day. Sims, by establishing a private hospital in his door-yard and perfecting a definite technique, placed the cure of loathsome fistula among the precious gifts with which the surgery of the century has blessed womankind. There was wisdom of rare quality displayed in the management of their cases and the technique of their operations—surgical wisdom that will stand as such when this century of surgical triumphs shall have closed; yea, when many centuries shall have rolled on to

[1] Read before Mitchel Medical Society, December 3, 1892.

the eternal past. The sound surgical principles they enunciated in requiring the women to come to their homes where they could have the personal attention of the operators, are bearing fruit; for patterning after their surgical ideas the successful specialists of the civilized world are now requiring that patients needing gynecic surgery shall leave their homes and have the work done at the specially equipped hospital of the surgeon. These remarks are for the purpose of fixing in the minds of the profession the fact that vaginal extirpation of the uterus is opening the peritoneal cavity, and that in this operation the lines of surgical effort must converge to, and not diverge from, such care of patients, perfection of technique, and simplicity in operating, as has given such phenomenal results in opening that great lymph sac above the pubes.

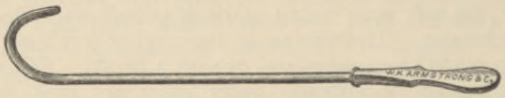
It is true that a given operator may persist in performing a faulty operation until he attains measurable success. The wise operator, however, will exchange his method for one which reason teaches him is more perfect. The operation which I here describe comes, in my judgment, as near parrying criticism as any with which I am familiar.

Position of Patient.—In my last thirty-six operations I have placed my patient in the Sims position, using the ordinary Sims speculum with a short but wide beak. I have found what is to my mind a decided advantage in the use of this position over that of placing the patient upon the back, and am surprised that eminent operators who favor the Trendelenburg position, because the intestines and omentum are retracted from the field of operating, do not avail themselves of the Sims position in vaginal hysterectomy for the same reason.

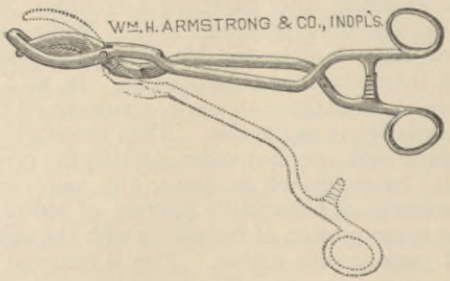
Aseptic Precautions.—Even when the uterus is not cancerous extreme precautions must be taken, otherwise the peritoneal cavity will become infected. It is vastly more difficult to thoroughly cleanse the vagina of all poisonous secretions, including the interior of the uterus, than to clean the abdominal wall sufficient for a safe ab-

dominal section. After the vagina and cervix have been thoroughly cleaned, our manipulation may cause to pour out from the cervix secretions that are poisonous, thus establishing infection of the peritoneum. During the five days preceding the operation I use repeated vaginal irrigations, using large quantities of soft soap and soft water, the soft soap being made of potash and olive-oil by a chemist. The vagina is thoroughly scrubbed with a mop made of coarse gauze, or with a brush. Following these, irrigations with soft warm water are used, with a Hildebrand's douche, to get the benefit of running water. At the time of operation the cervix is cauterized freely through the internal os with an iron poker heated in the fire. The cervix is then packed with a bit of gauze saturated in a solution of the persulphate of iron. The external os is then stitched with three or more stitches so arranged as to secure inversion of the lips. If the uterus is cancerous and the cervix ulcerated, these precautions are not, in my judgment, sufficient. I do not think that sufficient antiseptic precautions can be taken at one sitting. Therefore after curetting I continue the antiseptic irrigation for at least one week. While using the anæsthetic twice is objectionable, a possibility of septicæmia is infinitely more objectionable. In such cases I use, under an anæsthetic, a curette, removing all necrotic tissue as completely as possible. Then thoroughly washing the parts with very hot water, packing the cervix and fundus, if I have curetted the same, with gauze saturated with a solution of Churchill's tincture of iodine, I also scrub the upper portion of the vagina with the same solution and pack it with cotton. This is removed in two days, sooner if necessary. The irrigations with soap and water are continued until from a week to ten days has elapsed. During this time the patient has been taking full doses of strychnia or nux vomica, combined with iron, precisely as in all my cases where I expect to open the peritoneal cavity. Then I venture upon the extirpation in the following manner: Emptying the bladder with a

catheter at the last moment, carefully mopping the parts again in the region of the urethra, casting out of the work any sponges or mops that have been used for cleansing purposes, the parts are seized with two tenacula, one catching the cervix and the other the mucous membrane



in front of it. These are given to assistants. Then with scissors curved on the flat I make a semicircular incision through the mucous membrane, clipping my way with tenacula and scissors between bladder and uterus[1] until the peritoneal cavity is open. The serous membrane is then brought down over the bladder and stitched to the mucous margin. The angles of the incision are widened as far as the broad ligaments. In each angle a stitch is taken which holds the serous to the mucous membranes.



A large flat sponge, with ligature attached, is carried through into the abdominal cavity and left there to protect intestines and omentum from atmospheric contact. Douglas's cul-de-sac is then opened by an incision, the

[1] The mucous membrane may be removed at some distance from the cervix, if we go to the cervix immediately beneath it.

angles of which unite with those which have just been stitched. The uterus is then simply attached by its broad ligament. A strong ligature is then carried around the broad ligaments with a blunt hooked needle, the point of which is kept close to the uterus as it is inserted. The needle is withdrawn and the ligature tied. This brings the broad ligament to a round mass. The staff grooved on its concave surface is then passed through the anterior incision, following the track of the ligature, its point emerging in the posterior incision. By this staff the now rounded broad ligament, not the uterus, is brought down where a single clamp may be applied in a safe and definite way. Or the ligaments may be tranfixed with three or four ligatures without repeatedly introducing the fin-

gers to keep your needle from catching up what is not wanted. I can see no advantage whatever in dragging down the uterus. There is surely less room in the vulva than higher up. I can see advantage in dragging down and fixing with the staff, in a definite way, the ligament which we wish to make secure against hemorrhage. This is repeated upon the opposite side and the uterus extracted, when it will be found that the stumps of the ligaments are well down in the vagina, and a stitch which first gathers up the serous membrane near the bladder, then gathers the serous covering of broad ligament above the first rounding ligature, then catches the serous membrane of the posterior incision, when tightened, will fix the broad ligament out into the vagina. The opposite side being treated in a similar manner leaves the serous membranes touching each other between the stumps. The advantages of this method are several. First, there is nothing, not even a stitch, left within the peritoneal cavity. If an abscess should form in the broad ligament, as is sometimes the case, the pus pours out into the vagina.

If the ureter has been severed, we have a definite cicatrix, and the urine will be poured into the vagina. One of the greatest advantages, however, in fixation of the broad ligaments in the upper angle of the wound is that it drags up the vagina and secures the patient against prolapse of that tube, with its resultant cystocele and rectocele, which followed in all my cases before I took this precaution to first round the broad ligaments and so fix them as to drag the vagina upward.

Early Diagnosis.—The vital point in connection with this operation which is now offering hope to those heretofore hopeless women, is an early detection of any tendency toward malignant disease of the uterus. This is forcibly impressed upon my mind almost daily by cases coming to me where the disease has extended beyond the perimetrium, so that it often seems to me that a few months' earlier diagnosis and vaginal extirpation of the uterus might have given a hope. Others where the uterus, pelvic tissue, and organs have become so incorporated in one common mass that nothing surgical could be thought of. If vaginal extirpation is advisable at all, doubtless there was a time in these far-advanced cases when an operation would have offered some hope. One of the greatest obstacles in the way of early diagnosis and early operating is the time-honored but accursed heresy that the woman must have hemorrhage, purulent discharge, pain, emaciation, etc., all attributable to the menopause. Whereas, if a woman at the age when she might expect the approach, the climax, or termination of the menopause, has any other symptoms whatever than a painless, odorless, and harmless cessation of her flow, an expert ought to be consulted and the cause of this deviation from the symptomless cessation of her menstruation determined. Professor William Goodell, of Pennsylvania, has recently, in his forcible and inimitable way, called attention to the great advantages of an early diagnosis in such cases. Another heresy being taught the laity by some members of the profession, and in some of the text-

books, is that uterine cancer could not exist without pain. Some three cases, however, have come under my observation where there was not one particle of pain during two years of the progress of the disease, nor, in one case, until an excavation in the uterus large enough to contain the fist had been formed. So if we are to detect disease early we must ignore the idea that pain is an essential factor in the diagnosis.

I append to this paper a list comprising forty cases of vaginal extirpation of the uterus with four primary deaths. In the fifth case the death was within three days after the operation, but the patient was already insane, and after the second day no medication whatever could keep her in bed, she dying the third day from cerebral exhaustion. I do not think the death of a raving maniac should be counted as figuring for or against an operation which is on trial as a sort of new gospel for a class of women to which medical science heretofore could not even offer a respite from death from a most torturing, filthy, and loathsome disease.

Primary Deaths.—CASE I.—Mrs. C——; patient nearly dead of hemorrhage. Duration of disease nearly two years. Dr. Long, of Indianapolis, attending physician.

CASE II.—Mrs. G——; operation June, 1889. Broad ligaments contained a cancerous mass. Disease had existed over two years. Dr. Bunell, attending physician.

CASE III.—Mrs. M——; operation September, 1890. Septicæmia the third day. Disease had existed over two years. Dr. A. L. Wilson, of Indianapolis, reference physician.

CASE IV.—Mrs. D——; operation November 29, 1891. Nearly exsanguineous from hemorrhage. Disease had existed over two years. Dr. Records, of Lawrence, attending physician.

Non-surgical Cause.—CASE V.—Mrs. B——; operation November 3, 1891. Patient died from acute mania. Dr. Bence, of Greencastle, attending physician.

In Cases I. and II. the disease was far advanced into the broad ligaments and the operation should never have been undertaken. The cases, however, were deceptive, and proved during the operation to be worse than I had anticipated. Other cases have turned out better than my former examination had led me to hope. The third case in this primary list was extremely anæmic from having lost great quantities of blood. The fourth case had suffered from the disease over two years; had lost enormous quantities of blood. Notwithstanding this, I believe she could have lived a few months could I have first curetted the uterus so as to have stopped the hemorrhage, then built up new blood, and later removed the uterus. She was too feeble, however, to be removed to my private hospital, and at that time I had not become convinced that a period of time, at least a week, should elapse between the time of removing the necrotic tissue and the opening of the peritoneal cavity. This is a principle connected with this operation which I shall insist upon in the future, to wit: That the cavity of the uterus and the vagina shall be, if possible, rendered as thoroughly aseptic as the abdominal surface when the peritoneal cavity is to be opened.

Secondary Results.—This list comprises thirteen cases that have died since the extirpation of the uterus at different periods. That the profession may have the opinions direct from the doctors who trusted me to make these operations, I sent out the following questions:

"To the end that the profession may know the real advantages of, and benefits derived from, vaginal hysterectomy, will you be kind enough to answer the following questions and return the same to me:

"1. How long did Mrs. —— live after the operation was performed? 2. From what you know of this case, and of cases where no operation was made, did she derive sufficient benefit, prolongation of life, etc., from the operation to justify you in advising similar operations? 3. Was the latter part of her life attended with more or

less suffering than those who go down and die where the uterus is not removed? 4. Have you any thought or suggestion to add as to the advisability or non-advisability of the operation?"

The answers show that two of the cases died, the one from grippe and the other from peritonitis, and up to the time of death there had been no return of the disease, leaving eleven cases that died from return of cancer.

CASE I.—Of secondary death, Mrs. G——. Dr. E. E. Carey, of Indianapolis, in answer to my circular letter says: "The operation on Mrs. G—— was a success as regards removing the uterine cancer, and had the operation been made sooner I think the patient would have entirely recovered. If I had the same case to deal with, would advise the operation of entire removal of the uterus."

CASE II.—Mrs. M——, died sometime after operation. I do not know who her physician was.

CASE III.—Mrs. A——, of Greencastle. Her attending physician answered the list of questions in my circular letter as follows: "1. Eighteen months. 2. I think not. 3. About the same. 4. None whatever. I am willing to leave the advisability of surgical interference to those whose observations and experience enables them to decide more intelligibly of the propriety of the operation than can be done by the general practitioner.

"Respectfully,

"G. C. SMYTHE."

CASE IV.—Mrs. C——. Dr. Carey, of Indianapolis, attending physician, writes: "Mrs. C——, after being operated upon for entire removal of the uterus made a good and rapid recovery and gained in weight thirty-five pounds in five weeks. The patient told me herself that she felt better than she had for years. She died fourteen months after the operation. Death was from uræmia, caused by the damming back of water in the right ureter. If I had the same case, or one similar, should advise the same operation."

CASE V.—Mrs. S——. Attending physician answered the list of questions in my circular letter as follows: "1. About one year. 2. Yes, the pain was infinitely less, and the offensive discharge a trifle to what usually accompanies cases without operation. 3. The result in this case was eminently satisfactory to me, and consoling to the friends. 4. I would advise operations in every case practicable as the best palliative and the only treatment that gives promise of suspending the disease, and certain to prevent that offensive discharge which is so mortifying to the poor victim and friends. Having followed several cases down the dreary road of non-interference, I would advise all to avoid that road regardless of the prospect of suspension of disease or prolongation of life.

"Cordially,

"J. M. GRAY.

"NOBLESVILLE, IND."

CASE VI.—Mrs. F——, Goshen, Ind. Attending physician answered the list of questions as follows: "1. I think Mrs. F—— lived about ten months after the operation. 2. As to the prolongation of her life, I feel that the operation did not shorten her life, and from what I have seen of others who did not have an operation performed, her suffering was less than those, and I would advise an operation every time. If success was only one in a thousand it would be advisable. 3. I think the latter part of her life was attended with less suffering than those who have no operation performed. 4. As above stated, I would advise an operation every time, as there is a chance of life a longer period, as I have seen those who have had the uterus removed twelve or fifteen years and are at this time in good health, otherwise death would have ensued in a few months.

"Kindly yours,

"W. W. WICKHAM."

CASE VII.—Mrs. L——, Pendleton, Ind. Attending physician answered the list of questions as follows: "1.

Patient lived about eighteen weeks. 2. Her life was prolonged fully one-half. 3. Less suffering. 4. Mrs. L—— lived at least two months longer, picked up in flesh and strength so as to go about; suffered much less pain. Discharge was much less offensive when it did occur.

"Respectfully,

"JOHN W. COOK.

CASE VIII.—Mrs. U. W——, Midleton, Ind. No report. I hear she died of peritonitis from exposure. Dr. Murray was her physician.

CASE IX.—Mrs. B——, Carlisle, Ind. Attending physician answered the list of questions as follows: "1. About six weeks. 2. Yes, but would urge an early operation in all such cases. 3. There was much less suffering in her case than those who are not operated upon. 4. Would always advise as early operations in these cases as possible. If you could have had the case and operated when I first wrote you, at the time when you were absent in Europe, I am confident that Mrs. B—— would have been a living and well woman to-day.

"Fraternally yours,

"J. M. MATHES."

CASE X.—Mrs. F——, Indianapolis. Attending physician answered the questions as follows: "1. Not quite two years. 2. Yes. 3. Very much less.

"WILLIAM H. THOMAS, M.D."

CASE XI.—Miss R——, Kokomo, Ind. Attending physician answered the list of questions as follows: "1. Twelve months after operation. 2. Yes. 3. Less suffering, less odor, and less pain. 4. I approve of the operation. Had Miss R—— submitted to the operation when first suggested to her, I believe she would have been living. Early operations in cancer of the uterus is the treatment.

"I am, truly yours,

"WILLIAM SCOTT."

CASE XII.—Mrs. F——, Bloomington Ind. Attending physician answered the list of questions as follows: "1. Ten months. 2. Yes. 3. Less. 4. It should have been made sooner.

"Respectfully yours,

"L. T. LOWDEN."

With reference to the same case Dr. Harris answers as follows: "1. Died December 8, 1891. (Operation was performed February 3, 1891.) 2. Yes. 3. Less. 4. An early diagnosis of malignant disease of the cervix, followed by an early operation (vaginal hysterectomy) is the only safety to the patient. In further advanced cases, even before systemic infection, an operation is advisable, as it no doubt prolongs life and lessens suffering.

"Yours sincerely,

"JOHN E. HARRIS."

CASE XIII.—Mrs. M——, Indianapolis, Ind. Attending physician answered the list of questions as follows: "1. Something over one year. 2. She did. 3. With much less. 4. I should most assuredly advise the operation. In my judgment Mrs. M—— died of la grippe. This I believe to be the direct cause of her death. She was at my office two days before she was attacked with the above disease, and said to me that she was in better health than she had been for four years. She had become very fleshy and very well indeed. Her husband said to me to-day that he believed the operation was a success, and that if she had not taken la grippe she would have been alive to-day.

"Very respectfully yours,

"W. C. HALL."

From the ten replies to my circular letter it will be seen that the doctors (with but one exception, and in that case Dr. Smythe leaves such questions to the specialist) are emphatic in their statements that these patients

all derived sufficient benefit from the operation to warrant them in recommending it in similar cases. Answering the second question—was the latter part of her life attended with more or less suffering than those who go down and die where the uterus is not removed—their answers are nearly all emphatic that their sufferings are less and that they are greatly benefited by the operation for the relief from hemorrhages and the foul discharge. Answering the fourth question, as to whether they have any thought or suggestion to add as to the advisability or non-advisability of the operation, most of them insist that the earliest possible diagnosis and vaginal extirpation of the uterus is the treatment in all cases where cancer is diagnosticated.

Patients Living.

No.	Patients.	Date of operation.	Attending physician.
1	Mrs. H.....	June, 1888.....	Dr. William Scott, Kokomo, Ind.
2	Mrs. B.....	June 22, 1889	Dr. Wright, Kokomo, Ind.
3	Mrs. B.....	November 5, 1889...	Dr. Winans, Muncie, Ind.
4	Mrs. K.....	February 5, 1891	Dr. Phinney, Muncie, Ind.
5	Mrs. J... ...	March 21, 1891.....	Dr. Shields, Muncie, Ind.
6	Mrs. L.....	April 4, 1891	Dr. Waterman, Indianapolis, Ind.
7	Mrs. B.....	May 23. 1891	Dr. Kerns, Greenwood, Ind.
8	Mrs. B.....	May 26, 1891.....	Dr. Bence, Greencastle, Ind.
9	Mrs. M.....	October 6, 1891	Dr. Eastman, Indianapolis, Ind.
10	Mrs. M.....	October 6, 1891	Dr. Miller, Lebanon, Ind.
11	Mrs. H.....	November 12, 1891 .	Dr. Eastman, Indianapolis, Ind.
12	Mrs. T.....	November 19. 1891 ..	Dr. Newcomer, Tipton, Ind.
13	Mrs. M.....	December 16, 1891 ..	Dr. Earp, Indianapolis, Ind.[1]
14	Mrs. A.....	February 13, 1892...	Dr. Cooper.
15	Mrs. H.. ...	February 27, 1892 ...	Dr. Lutz, Indianapolis, Ind.[1]
16	Mrs. Z.....	June 30, 1892 . .	Dr. Eastman, Indianapolis, Ind.
17	Mrs. M.....	September 8, 1892...	Dr. Banker, Columbus, Ind.
18	Mrs. R	September 15, 1892..	Dr. Simeon Martin, N. Salem, Ind.
19	Mrs. D.....	September 27, 1892..	Dr. Thorne, Kokomo, Ind.
20	Miss H.....	October 12, 1892	Dr. Good, Warren, Ind.
21	Mrs. H.....	November 5, 1892 ...	Dr. Johnson, Kokomo, Ind.
22	Mrs. M.....	November 22, 1892 ..	Dr. G. R. Green, Muncie, Ind.

There is another class of cases in women who have passed the change of life and have irritating discharges

[1] I have two such cases cured.

from the endometrium. Curetting produces growths varying in size. The microscope often denies that the disease is malignant. For these cases I believe vaginal hysterectomy to be the most satisfactory treatment. Still another class of cases with uterine prolapse, or with extreme retroversion, who have worn all sorts of harness and supports and find life a burden in consequence of the continued uterine displacement. In such cases I believe vaginal hysterectomy is to be the treatment of the future. There is still another class of cases of hystero-neurosis, some of them bordering on epilepsy, others on the border line between sanity and insanity.[1] I believe to them vaginal hysterectomy would offer a hope of cure of both body and mind.

This operation will always be one very difficult of performance, and ought not to be undertaken by one who is not so situated that he will probably make the operation several times. I believe a high rate of mortality will follow the first efforts of most operators. The nimble wit in the ends of the fingers which enables the operator to avoid bladder, ureters, and bowels, is possessed by the few. This is to be considered. A large number of the patients demanding vaginal hysterectomy for cancer have repeated hemorrhages until they are very anæmic. There has been more or less absorption of the putrefactive product of necrotic tissue, poisoning the nerve-cells, and so vitiating the little stock of nerve force stored away in these citadels of life, that there is little left for the purpose of resisting shock. In other words, cancer saps the fountain of life and leaves its pitiful victims with but little stamina for successful surgical battle.

Corner of Delaware and Vermont Streets.

[1] I have two such cases cured.