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UNNECESSARY SURGICAL OPERATIONS IN THE TREATMENT OF THE DISEASES OF WOMEN.[3]

BY CLIFTON E. WING, M. D., BOSTON.

THAT there exists, at the present time, among those who practice the treatment of the diseases of women, too great a love for operative procedures, is an opinion frequently heard expressed by members of the medical profession. These statements are usually answered by the specialists with such remarks as "This specialty is a modern development, and physicians who have not given particular study to these troubles know little or nothing about them or their proper treatment." There is an amount of truth in such an answer which gives it weight; but, still, in this way the question is avoided rather than met. I have stated in a previous article[4] my belief that the operative part of the specialty is overdone. Having been repeatedly asked what operations were referred to I will call attention, in the present paper, to some of those most in vogue.

The fees which a gynæcologist can collect for the performance of anything which can be called "a surgical operation" are much greater than the amounts ordinarily earned in the honest treatment of cases by other and simpler means. Unscrupulous practitioners can much increase their incomes by doing as many "surgical operations" as possible. But with two practitioners, equally honorable, and each above a suspicion of sacrificing honesty to pocket, given the same number of similar cases, one will perform more surgical operations in their treatment than will the other. Much depends upon the physician's order of mind, and, perhaps, quite as much upon his early instruction on the subject and the character and practices of those who were his teachers and early associates.

While in the first years of the development of the specialty it was important that the profession should learn that there were certain surgical operations which would afford relief, — oftentimes in cases previously considered incurable, — yet, I think, that at the present time the pendulum has swung far to the other side and that eventually we shall look back upon the present "operative era" in gynæcology with somewhat the same feelings with which we now look back upon the time when all vesico-vaginal fistulæ were considered incurable, and women who were so unlucky as to have backaches from displaced wombs were blistered and cauterized along the back for "spinal trouble."

It has occurred to me that there is an analogy between

[3] Read at the meeting of the Norfolk District Medical Society, March 22, 1881.

[4] Modern Abuse of Gynæcology, read before the Suffolk District Medical Society, April 10, 1880.

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the present practice of many who treat female troubles and some of the orthopædic practice witnessed in my student days. We used to hear much about the proper method of excising the head of the thigh-bone in hip-joint disease; but little or nothing of value was ever told us about the methods of treating such troubles to prevent the advance of the affection to that stage where excision was a necessity, and the interest excited in our minds over the operation of excision was certainly as great as our interest in the welfare of the poor patients. Few of the students, the operations once through with, thought any more about the cases or ever knew much about the final condition of the patients.

I do not intend to consider in this paper the rare and exceptional gynæcological procedures. The operations to which I shall ask attention are some of those most frequently performed, namely: —

(1.) The Operation for Ruptured Perinæum.

(2.) Division of the Neck of the Womb.

(3.) The Operation for Restoring the Neck of the Womb where this has been torn. (Emmett's operation.)

(4.) Curetting of the Uterine Cavity.

(5.) The Operation upon the Anterior Vaginal Wall for Prolapse of this Portion and Cystocele.

I have purposely avoided the use of the several long and complex names, troublesome to pronounce and difficult to remember, which have been invented for these procedures. They are only confusing.

RUPTURE OF THE PERINÆUM: THE CONDITION NOT ALWAYS AN INDICATION FOR OPERATIVE INTERFERENCE.

Extremes meet in medicine as elsewhere. This fact is exemplified by the difference in the views held by physicians regarding the lesion in question. Some (usually practitioners well advanced in years), are disposed to consider the injury of little or no importance unless, perchance, the rupture is very extensive, involving, perhaps, the sphincter muscle and the rectum; while the most enthusiastic of those holding the opposite opinion tell us that "not a line" of the integrity of the part can be destroyed in labor without disastrous consequences to the woman, and advocate the operation for restoration whenever an opportunity for its performance offers. The accurate clinical observer learns from experience that, as is often the case where opposite views come in contact, the truth lies in a mean between the two extremes.

While the better knowledge of uterine affections which has come to prevail in late years has taught us that the perinæum (or, more properly, the "perineal body") is an important aid to the proper support of the pelvic contents, and that where it is destroyed or greatly injured, the woman usually, sooner or later, suffers more or less inconvenience; yet I question if those who take the extreme view of the matter and assert that every rupture, even if it is only a slight one, is followed by serious results, are not really doing much to retard the recognition of the true importance of the lesion. Practitioners of long experience, who know of instances of laceration of the perinæum, suffered years before, that are unaccompanied by troublesome symptoms, hearing such statements, will be apt to have their confidence in modern gynæcology somewhat shaken. On the other hand, young practitioners, with less practical experience, having patients with uterine symptoms, and finding, on examination, more or less rupture of the perinæum, may easily attribute too much importance to this condition, and overlook other troubles which are present. In a paper published some years ago[1] I called attention to the fact that physicians making a uterine examination, and finding what they had been erroneously taught to regard as "ulceration" at the neck of the womb, were apt to attribute all the patient's pains and aches to this condition, when really it was often of little or no importance, and therefore often failed to look further and detect the real cause or causes of discomfort. Some such caution regarding Rupture of the Perinæum, it seems to me, will not be out of place at the present time, when so much attention is being given to the subject.

I cannot but think that the evils attributed *to slight lacerations* have been greatly exaggerated. It is the exception, and not the rule, to find in women who have borne children a perinæum perfectly intact, and it is a mistake to take as a fixed standard of what every perinæum should be that condition found in nullipara and virgins. Not only are the parts more relaxed and patulous as the result of the distension in child-bearing, but, as Matthews Duncan has pointed out, there is invariably more or less rupture of the vaginal outlet during parturition even if the perinæum proper is not torn, and if the condition found in those who have not borne children is to be assumed as the proper condition for all women, then an operation may easily be found "necessary" in practically every woman who has had children.

I am free to state that I have not found that patients with slight perineal laceration (and many have come under my notice) have suffered from this condition the direful symptoms which have been described as accompanying such lesions. It has been truly said that the sole justification of any operation must be the strong probability that compensating good will be the result. Under such a rule of action I believe that the cases of slight perineal lacerations requiring or justifying surgical interference will be few. One writer, after calling attention to the fact that marked lacerations suffered years before sometimes remain absolutely without injurious results, pointedly remarks of women having slight lacerations, "It is significant that they suffer more after their attention has been drawn to the injury." This is a hint enthusiastic operators will do well to consider.

Neither in all cases where the *perinæum is more extensively ruptured* is the operation always advisable. A great American gynæcologist has put forth the following as aphorisms: "Given a woman with a perfect perinæum, and the relation of the parts within the pelvis will be perfect: destroy that perinæum and at once the parts will fall out of position; restore the perinæum, and as soon as it is perfect all the pelvic organs will be restored to their normal relations." It is difficult to conceive of teachings better calculated to mislead. The idea that a woman with a perfect perinæum cannot suffer from flexion, version, or prolapsus of the womb, and displacements of the other contents of the pelvis is nonsense, as every physician knows, and that when there is a rupture of the perinæum and at the same time displacement of the parts within the pelvis, the simple repairing of the perinæum is always

[1] On So-Called Ulcerations of the Os-Uteri. Boston Medical and Surgical Journal, March 16, 1876.

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to insure the restoration to their normal relations of all the pelvic contents is equally absurd.

When the injury to the perinæum threatens, if left unrepaired, to impair the supporting powers of, and to produce displacements of, the other parts which are, as yet, in practically normal condition and position, and we can feel that the operation of restoring the perinæum is going to remove this danger and relieve and cure the patient, most certainly the operation should be done. But in many cases — nay, *most* cases, this lesion is *only one of a series* of sequences of child-bearing. The woman, with more or less absence of perinæum, often, at the same time, has subinvolution of the uterus, the organ being much heavier and much larger than normal, perhaps more or less rupture of the neck of the womb, subinvolution of the vagina, and a relaxed condition of all the tissues of the pelvis, allowing the heavy womb to "sag," or to become displaced in one direction or another.

Since these other results of child-bearing are enough to cause serious displacements and serious symptoms in very many cases where there is no perineal rupture, how, in cases where this lesion coexists, can the simple mending of the torn perinæum "restore to their normal relations" all the pelvic organs, "or furnish complete relief to the patient? Now, in just such cases I have known physicians to tell patients that all they needed was to have the perinæum restored, and the latter to submit to the operation only to be disappointed in the relief afforded by it. In fact, the patient is often worse off in one respect, after having undergone the operation, than before. It is just this class of patients with heavy wombs and relaxed pelvic tissues who derive the greatest benefit from the support afforded by properly adjusted pessaries. Now, with a more or less patulous vulva the patient can usually learn to manage her own supporter when it is once properly fitted, removing and replacing it herself as is necessary; but the perinæum restored by operation, and restored as thoroughly as it usually is by the better operators, *as it must be to afford much support to the parts within*, the patient, as a rule, cannot replace her own supporter; indeed, in many cases can remove it only with difficulty, and therefore for the future is dependent upon the doctor; which is good for the doctor, but bad for the patient.

With this class of patients I believe the perineal operation should be reserved for the cases where supporters alone fail to give the desired relief (and such cases will be common in direct ratio with the physician's want of skill in adjusting pessaries), and those cases where, after the wearing of pessaries for a long time, the patient is so desirous of doing without them as to be willing to undergo an operation, and there is fair prospect, the parts having been kept in position so long, that now, if the perinæum is restored, artificial supports can be dispensed with. Few patients are so anxious to throw aside a supporter which has given comfort, and whether they are going to be able to dispense with one permanently is always a question.

The mistaken notion so common among physicians that where a lever pessary is to be worn a firm, solid perinæum is necessary for it to rest upon, has doubtless often led to the performance of perineal operations which might have been avoided had the surgeon been an expert in the adjusting of pessaries, and known the fact that well-fitted ones do not rest upon or even touch the perinæum or perineal body.

Lacerations involving the sphincter muscle and the rectum of course always demand operative measures.

I have not referred to the *primary treatment of perineal lacerations*, that is, their treatment immediately upon the conclusion of the labor during which they have occurred. This subject concerns the obstetrician as much as it does the gynæcologist. On the one hand we have physicians who think the introduction of sutures at this time inadvisable, and, on the other hand, those who declare that the neglect to do this is reprehensible. The following is, I think, a fair general statement of the matter: —

In the great majority of cases sutures introduced with skill immediately after the injury has occurred, keeping the torn surfaces in apposition, will give the woman comfort, and increase the chances of a good union, although, of course, it may not take place. In many cases where the sutures are used they are used with such want of skill and in such bungling manner that they fail to insure apposition of the parts, in fact, act merely as setons to increase inflammatory action, and if a good union is obtained, it is not because of the sutures, but in spite of them. In certain cases, owing to the condition of the puerperal woman, it may be bad practice to attempt the primary treatment of the lesion. Such cases are exceptional, however. The "diminution of the chances of septicæmia" by the closing of ("even slight") perineal wounds, which has been much dwelt upon of late, would seem to have been rather exaggerated.

DIVISION OF THE NECK OF THE WOMB.

It is questionable if any other operation of modern surgery has been quite as thoroughly overdone and abused as this has been. Fortunately, the operation is not now as fashionable as it was some years ago, but the evil effect of the teachings of certain leaders in the specialty has not yet fully passed away.

In the last seven years I have performed the operation but twice. These two operations were done in the earlier years when I was fresh from seeing the practice of those with whom it was a frequent and regular procedure, and whether I should now, with my present ideas, repeat the operation in two similar cases is very doubtful. During this period I have had many patients upon whom I should have operated had I followed the practice of some gynæcologists of the day, but I do not think my patients would have been benefited thereby.

The operation is usually done to render the uterine canal patulous and straight in cases where it is supposed to be unnaturally narrow or crooked, the object being the relief of dysmenorrhœa, of sterility, etc., etc.

That cases do occur where the operation is indicated and advisable I believe, but that such cases are very rare I am convinced. It is only a short time ago that the operation was very often resorted to. It seemed as if gynæcologists divided the cervix uteri simply because they did not know what else to do. Practical experience soon robbed the operation of much of its repute and glory, but patients still come along, every now and then, who have had the operation done upon themselves or who have been advised to submit to it, when from the nature of their cases such an operation could not prove advantageous. I have had patients who had been told they must be treated for stricture of the uterine canal where the largest sound passed without obstruction to the fundus.

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"Stricture of the uterine canal is not infrequently diagnosticated when in reality no 'stricture' exists. When there is an inflamed condition of the lining of the womb the calibre of the canal is often much diminished by the coincident swelling, and in cases of displacement leading to hypostatic congestion the consequent œdema and swelling of the uterine tissues often leads to the same narrowing of the uterine canal, which is most readily detected with the sound in the neighborhood of the os internum, that being normally the narrow part. But to treat such cases as though this secondary condition were the prime cause of the troubles present does not seem rational.

"Again, when the examiner finds difficulty in passing a sound, he is very apt to jump to the conclusion that a stricture is present, when perhaps such is not the case, and the fault is his own. Where the old-fashioned cylindrical speculum is used (and no one at the present day would base a diagnosis of stenosis of the uterine canal upon difficulty in passing the sound by the touch alone, and without the use of any speculum) it is, in many cases, an impossibility for any one to be at all sure whether a stricture is present or not; for, owing to the fact that the uterine canal is not in a line with the speculum when the latter is introduced into the vagina, but often nearly at right angles with it, a sound cannot always be readily passed through this speculum into a normal uterus. The valvular specula are rather better in this respect, but may lead to error in another way, as I have several times seen. Unless carefully managed the end of that blade which lies along the anterior vaginal wall may very easily be pressed against and be made to indent the anterior wall of the uterus, so as to obstruct the uterine canal to a degree that the sound will not readily pass. The Sims speculum shows its superiority here as elsewhere, but its proper use necessitates the aid of a trained assistant."

It is suggestive that at a meeting of specialists, not a great many years ago, two practitioners, each of great experience, and with large practices, discussed the subject of uterine stricture. The one thought that it practically never occurred at the os externum, but was more common at the os internum, while the other held exactly the opposite opinion. I believe it is rare at either place to the extent to require surgical interference. In some cases where the physicians have considered the uterine canal too narrow or crooked they have recommended the surgical interference when there was nothing whatever to indicate that the condition caused symptoms. Could anything be more ridiculous than such advice given in the case of an unmarried lady whose menstruation was painless. (The lady afterward came to consult me, and asked if I would recommend the operation.) I even know of an instance where a physician, recommending the operation because he thought he found the uterine canal more crooked than usual, and being met by the patient remark, "But, doctor, I never have pain when unwell," replied, "But you may have pain in the future if the womb is left as it is." This was certainly a marked example of preventive medicine or rather preventive surgery! Some time ago I reported, in conjunction with Dr. A. N. Blodgett, of this city, a case of uterine fibroids where the uterine canal was so crooked and narrowed that a small probe could not be passed. Indeed, it was difficult to trace the canal on section of the uterus post mortem. Menstruation had been always painless! It is interesting to think of these two cases in the same connection.

Division of the cervix to straighten the uterine canal where its crookedness is due to uterine flexion is an operation the beneficial results of which have been very much overrated. There are better and simpler ways of treating uterine displacements, and when these fail division of the cervix will rarely prove beneficial.

The operation itself is very simple. Any one can do it, but no one can truthfully assure his patient that it is unaccompanied with danger. I have seen more than one very serious result follow. To be sure when they come they are generally attributed to the fact that the patient has "taken cold," or to some cause other than the operation itself, but safe to say in most of these cases the trouble would not have come but for the interference of the doctor.

(To be concluded.)

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Original Articles.

UNNECESSARY SURGICAL OPERATIONS IN THE TREATMENT OF THE DISEASES OF WOMEN.[1]

BY CLIFTON E. WING, M. D., BOSTON.

THE OPERATION FOR RESTORING THE CERVIX UTERI WHERE THIS HAS BEEN RUPTURED. EMMET'S OPERATION.

Curiously enough, while a short time ago "*division of the neck of the womb*" was the gynæcological fashion, now its exact opposite, "*the closure of the neck of the womb*," when this has been divided by nature or art, is the popular operation of the day.

When Dr. Emmet clearly described the condition which had been (and, even now, still is) so often mistaken for "ulceration of the womb" and devised an operation which might be employed for its cure, in cases where such a course was called for, he did a good thing for gynæcology. In former days "ulceration" was the "bête noire" of those who treated women's diseases, and cauterization with nitrate of silver or more active agents was the "proper treatment." Dr. Emmet's exposition of the real condition of the parts has done away with much of this malpractice which had its origin in ignorance. But if every woman with a laceration at the neck of the womb is to be considered a fit subject for a surgical operation, without regard to whether this condition is really a cause of troublesome symptoms or not, then the discovery of Dr. Emmet is to prove anything but a boon to womankind.

Most women who have borne children present more or less of this lesion. Many have rupture and eversion of the neck of the womb without symptoms. Certain ones suffer from this condition. Measures of treatment directed to this lesion, it is needless to say, should be reserved for these last cases, but there is at present, in America, at least, a marked tendency to resort to the operation devised by Dr. Emmet, whenever the condition of eversion is found, whether it be a cause of suffering or not. It is true that by this means the typical conical form of the neck of the womb can be restored, but it is also a fact that very many of these women are not going to be benefited thereby.

A western physician has recently written so clearly upon this operation that I cannot do better than quote freely from his article.[2] After stating that the operation "has reflected unstinted credit upon its author, Dr. Emmet," he proceeds: "But I am afraid the disposition is just now to a too frequent resort to this serious operation. It is my conviction, and I know that there are many others who think as I do, that this procedure, so useful in its place, is being done far more often than there is any need for, and that there are many who are beginning to look upon it as a panacea for nearly all the forms of cervical disease. All new discoveries have to pass through what might be called an exaggeration period before they at length settle down to their proper level. So with the operation in question. There is something so simple and direct about it as to make it almost captivating to the surgeon's eye. Here is nature at fault, as usual, and art coming triumphantly to her relief with a neat plastic operation. Could anything be plainer? One writer in his enthusiasm advises the measure even after the ordinary slight laceration of labor; which is simply throwing overboard all faith in the restorative powers of nature. Proceeding on such a rule, nine tenths of parous women would have to be made the subjects of surgical operations. Let it be remembered that a certain amount of laceration accompanies every labor, whether normal or abnormal. Let it be remembered, too, that the cervices of all women who have borne children present evidences of puerperal tearing, all the way from slight irregularities of the os to clefts extending deep into its structure. Is there any one of us who has not again and again found such a condition coexisting with perfect uterine health? . . . . As far as my own practice goes, I must admit that at first I was much taken with the operation and performed it more often in former years than of late. There are many others who reckon their trachelorrhaphies in a similar declining ratio, although never ceasing to regard it as one of the most valuable contributions ever made to gynæcology. . . . . We live and think in cycles. Even fashion is subject to this law, and fashions in medicine have always characterized our science. The fashion of sewing up the uterus as an ordinary therapeutic measure may be expected to have its day, and then its true worth will be recognized — that of a most reliable, but serious and not often demanded, operation."

When gynæcologists recognize the truth of this last sentence then will the real benefits of Emmet's discovery be realized. Its effect so far has been in great measure the supplanting of the old treatment (by caustics, etc.) for "ulcerations" (which never existed), which, although it was misdirected and, in the light of our present knowledge, absurd, — yet was seldom followed by serious or fatal results, — by the performance of surgical operations, alarming to the patients and their friends, and which in a large proportion of cases are uncalled for and can be avoided. The fact is that very many cases of "rupture and eversion" (cases formerly considered "ulceration") require no treatment whatever, *i. e.*, the lesion is innocuous. Physicians have been rather led away by an exaggerated idea of its bad effects. For example, women with this condition have been solemnly assured by their doctors that unless they underwent operation for its cure they would never again become mothers, when perhaps the lapse of a few months has disproved such assertions and left the medical gentlemen in an awkward position.

The cases which are accompanied by troublesome symptoms and demand attention are the exception rather than the rule. If surgical interference is confined to such, Emmet's operation will be productive of much good. As at present often done, not because it is really needed but because a chance for its performance offers, it probably in the aggregate does more harm than good.

The operation is by no means devoid of danger. Phlebitis, cellulitis, pelvic abscesses, septicæmia, peritonitis, etc., have followed its performance by the best operators, and left results from which the patients would recover only after months of suffering, if at all. It is only a short time ago that a discussion in one of our local societies brought out accounts of several deaths after this operation. I myself have known of more than one such result.

The two operations last considered have been referred to, in a letter from London, in the following amusing lines: —

"When Dr. Sims was first here, he demonstrated, to

[1] Concluded from page 392.

[2] Paper read before the California State Medical Society, by W. H. Mays, M. D.

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the satisfaction of a great many people, and indeed seemed almost to have established it as a canon in practice, that a great number of women are suffering from complaints which require that the cervix uteri shall be lacerated to the extent of complete division; and we were under the impression that according to the well established experience of Marion Sims and his school, about twenty to twenty-five per cent. of the gynæcological patients are required to have the cervix uteri divided in order to be restored to health. But if now we find that at least as many are suffering from complaints which require that cracks, cuts, and fissures of the cervix shall be shut up, it seems as if the greater part of the energies of that most fearfully numerous, highly intelligent, and active class of practitioners, who, either as specialists or as family doctors, have a claim to the title of gynæcologists, will in future be divided between splitting up the cervices of those women who yet possess them entire, or uniting with horsehair or silver wire those which are by nature cracked or fissured. The general moral would then be open to deduction, that in respect to the uterus, whatever is is wrong, and whatever is not, ought to be brought about."

This is rather an exaggerated view of the matter, yet there is a good deal of truth in these lines. To my own knowledge, at one time a distinguished practitioner was doing many operations for dividing the neck of the womb, while an equally distinguished brother physician of the same city was industriously closing these cuts by operation and sutures, when the former's patients happened to fall into his hands.

CURETTING OF THE UTERINE CAVITY.

This is an operation which is being frequently performed at present. It consists in the scraping, with instruments devised for the purpose, of the inside of the womb (much as gardeners at certain seasons scrape trees), the object being the removal of morbid growths and excrescences, and the consequent checking of uterine hæmorrhage, etc. Formerly by the term "curetting" was meant a pretty serious operation, one which was comparatively rarely done, it being, as a rule, resorted to only when simpler means of controlling uterine flowing had failed, and when, in the absence of other apparent cause of hæmorrhage there was a strong probability that "intra-uterine fungosities of intractable nature" were present. To insure the removal of such growths the "curette" or instrument employed had a comparatively sharp (although not necessarily a "cutting") edge. With the increasing interest in the subject of diseases of women, such as has developed of late years, and the accompanying enthusiasm for "operations," naturally there has come an increased number of cases of curetting, until nowadays, if a patient presents herself with a simple uterine catarrh, and a history of increased uterine flow (which is but natural in such cases), and particularly if she have borne children, and has in consequence an "invitingly-open" uterine canal, perhaps the first thing the physician thinks about is the curette. But under this kind of practice the results with the old instruments were unsatisfactory. Too many patients were seriously injured, and some were killed, by the procedure, for even in the best hands, "curetting" if thoroughly done is a dangerous process for the patient to go through, and an operation which should always be kept as a last resort. The result was the introduction of a less formidable instrument in the shape of the "dull curette."

Now in most cases of common uterine catarrh the lining of the womb is more or less inflamed and swollen, and, from the presence of increased secretion, soaked and softened. The use of even a dull curette, under such circumstances, will, almost always, result in the removal of more or less of the softened lining, with, perhaps, a few distended and swollen glands; but in such cases the proceeding is not at all necessary, for, the catarrh checked by proper means, the parts will soon return to a normal condition. I have several times seen the dull curette used under such circumstances, and what were termed "characteristic granulations" removed and exhibited with satifaction by the operator to those present, when I have afterwards taken some of these "granulations" and "teased them out" under water and seen them resolve themselves into strips of apparently normal uterine membrane, which had evidently been rolled up into little balls before the edge of the curette, as snow is rolled into balls by children, thus deceiving the operator.

The great difference in the views held by physicians as to the dangers of "curetting" is explained by the fact that one set of physicians mean by this term the thorough operation done with the sharper instrument; an operation reserved for cases where other means of treatment have proved of no avail, therefore a comparatively rare operation, and, from the nature of the case, a pretty serious one; while with others of the profession "curetting" is a common method of treatment resorted to whenever any excuse offers, the *dull instrument* being employed. The procedure, as performed under such circumstances, is often hardly worthy of the name "operation," although the opportunity of using this term is seldom missed by those who practice it,[1] and in many cases has very little effect for either good or evil. But this is not true in all cases. In some conditions of the endometrium, where it is in an unhealthy relaxed condition, and it is desirable to "set up a healthy action" as our forefathers in medicine would say, the stimulating effect of the use of the dull curette may prove advantageous, and the dull curette will, in some cases, if used with skill, remove *soft growths* successfully, but it will prove inefficient in the case of many of the harder growths and granulations so difficult to manage with ordinary means, for which the operation of curetting was formerly reserved. Many a gynæcologist has learned this fact from experience, and, after several "operations" with the dull instrument, has finally overcome the difficulty by using the sharper instrument. As one writer has said of the dull curette, "It is an excellent instrument where nothing is to be removed;" but in such cases other measures less alarming to the patient will usually suffice.

Although in careful hands rarely productive of bad consequences (even when *used*, and not merely played with, as is often the case), yet there is a tendency in certain quarters to regard the dull curette as an instrument safe for any one to experiment with, and one which the merest tyro in practice need not fear to make use of. A caution may not be amiss. No one

[1] I have been surprised at the way the term "operation" is used, even by some physicians of good standing. I have repeatedly been told by persons who have come to see me about patients coming under treatment that the cases were probably serious ones, because the patients had already gone through so many operations, when later I have found the "operations" referred to, consisted, perhaps, in the application of some mild remedy to the cervix, perhaps, in the use of a uterine sound, or, it may be, in the attempt to place a supporter! Doubtless, such a use of the word has the advantage of making a due impression(?) upon the patient and her friends.

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should attempt the use of a curette, sharp or dull, who is not sufficiently experienced in uterine examinations to assure himself of the absence of all pelvic inflammation, even slight. The presence of such inflammation, which, when slight and localized, is not always readily detected by the inexperienced, often leads to uterine flowing; but under such circumstances curetting would probably make bad work. Even the use of a sound is not advisable in such cases. Again, the physician's office, from which the patient must return home, is not the proper place for the procedure. Physicians often ignore this fact with impunity; but I cannot but think it is making the patient run an unnecessary risk. She should be where she can lie quiet for a day or two, and longer if advisable. Occasionally there is severe hæmorrhage with the operation, even with the dull curette, and no one can tell beforehand with which patient it will come.

Dr. Emmet has devised forceps for removing granulations, etc., from the uterine cavity, which are very efficient, and render the resort to curetting but seldom necessary; but I do not think they quite take the place of the sharp curette in all cases. I have used both to advantage in the same case. Once, I recollect, the hæmorrhage was so rapid after removing some growths with the forceps, that I was forced to give them up, and finished the operation successfully by very rapid curetting, which brought away the rest In certain quarters the "sharp curette" has been decried as a barbarous instrument, one which should never have been invented, etc. It is its unnecessary and heedless use which has brought it into such ill-repute. It need never be so keen-edged as to merit the name of a "cutting instrument," and used with proper skill in proper cases it supplies a place the dull curette cannot fill. Emmet's forceps are excellent for the removal of placental tissue and other products of miscarriage; and here another word in regard to the use of the curette. It should be avoided if possible after miscarriage or labor, while the walls of the uterus are undergoing involution and the accompanying fatty degeneration. (Here Emmet's or other forceps can be used with much greater safety.) I have known neglect of such caution, and the rash curetting of a patient a few weeks after the confinement, followed by fatal consequences.

THE OPERATION UPON THE ANTERIOR VAGINAL WALL FOR PROLAPSE OF THIS PORTION AND CYSTOCELE.

When there is a tendency of the anterior vaginal wall, with the adjacent bladder (cystocele), or without it, to sag and protrude through the vulva, an operation, consisting in either the "folding in" or the removal of the slack of the vagina at this point, has been devised to correct the condition and afford relief to the patient from the "bearing down" bladder distress and other symptoms referable to it.

This "sagging" of the anterior vaginal wall rarely takes place to a troublesome degree unless there are other abnormal conditions present, notably, rupture of the perinæum, or some one of the uterine displacements, bringing the cervix, and with it the upper part of the vagina, nearer the vulva. Oftentimes a "sagging uterus" is present. With an absence of more or less of the perinæum the vagina fails to get its usual support, and with a lowering of the womb the anterior vaginal wall, no longer extended to its normal length, naturally tends to sag. In this way a low position of the uterus often has much to do with the production of this condition. Unfortunately, in a large proportion of these cases, the conditions named are not the only abnormal ones present. Such patients are apt to have the womb left large after confinement; a heavy weight upon its weakened supports. If such a patient goes through the operation on the anterior wall to reduce the vagina (preceded very likely by the operation for rupture of the cervix, if the physician is enthusiastic over modern operative gynæcology) and later the operation for ruptured perinæum, *since the weight of the heavy womb still remains she does not always get as much relief as can be given in many of these cases by the proper adjustment of a pessary without operative measures*, and perhaps after going through all the operations the patient will still have to wear a supporter to be comfortable. Indeed, where there is this heavy womb, with a relaxed condition of the pelvic tissues, a combination often found in practice, it is a very difficult matter and sometimes an impossibility to so constrict the vagina by any operation as to afford complete and lasting relief to the woman. In such cases it is often perfectly feasible, without any operation, to adjust a lever or other pessary, which the patient can herself remove and replace, which will raise the womb into place, and extend the vagina its normal length, so that practically no falling of the anterior vaginal wall is left. If the extending of the vagina is not alone sufficient then the lower end of a lever pessary may generally be so bent as to be of some additional service in keeping the falling anterior vaginal wall in place.

It has repeatedly happened to me to see such patients who, having tried various supporters without relief, had been led to think operative measures necessary, who, much to their surprise and delight, have been relieved completely by the aid of a proper pessary. Some, who had been so thoroughly imbued with the idea that an operation was necessary, if they ever wanted to be comfortable, as to seem almost disappointed when I did not urge such measures at once, have experienced such relief from a pessary as to express indignation that they were ever told an operation was necessary for them.

While I believe of this operation, as I believe of each of the other operations considered, that in its proper place it is capable of much good, yet I believe of it, as I believe of the others, that at present it is done much oftener than is necessary or best.

Patients suffering from these troubles are not infrequently told that they must undergo surgical operations before they will be able to wear a supporter. Occasionally such conditions exist that this is the fact, but with proper knowledge of the adjusting of supporters these cases will prove rare, much less frequent than they are at present considered. Comparatively few practitioners are in any sense experts in the fitting of pessaries, yet a thorough knowledge of their uses is as necessary to the gynæcologist as is the knowledge of splints and other apparatus to the orthopædic surgeon. This knowledge on his part frequently saves his patients from operative interference, and the same is true of a thorough knowledge of the pessary and its uses on the part of the uterine specialist. At present any new invention in the shape of a supporter needs but one thing to make it attain popularity in the profession at once, however it may fail otherwise. If it be only easy of

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introduction without paining the patient it is sure of a run for a while at least. The so-called "soft cotton pessary," highly recommended because it can "be worn where the womb is too tender to bear the pressure of a common supporter" (the fact being overlooked that a properly fitted lever pessary does not come in contact with that organ), highly efficient in creating a stench if worn even a short time, and good for little else, but easily introduced by anybody into the patient's vagina without causing pain, is a good example of this fact.

Dr. Engelmann, of St. Louis, has recently published an article entitled The Dangers Incident to the Simplest Uterine Manipulations and Operations, in which he has collected many bad results following the common gynæcological procedures and operations. Naturally, in recording the bad results, he was confined in great measure to the reported cases. Could he have known of the cases not reported his examples would have been multiplied manifold. I regard the paper as a most valuable one at the present time, and as possible evidence of a coming reaction from the "operation fever" which has afflicted gynæcology of late years. It certainly is a warning to the profession not to regard gynæcological operations too lightly. If we can go a step further, and lead physicians to realize that the operations now so much in vogue can often be avoided, it will be another step in the right direction.

A former Harvard professor often quoted the saying, "Meddlesome midwifery is bad." He might have truthfully added, "Meddlesome gynæcology is even worse."

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Miscellany.

"UNNECESSARY OPERATIONS IN UTERINE SURGERY."

MR. EDITOR, — I have read with much interest the admirable paper On Unnecessary Surgical Operations in the Treatment of the Diseases of Women, by Clifton E. Wing, M. D., recently published in the JOURNAL. With the doctrines therein enunciated I fully concur. His statement that "*lacerations involving the sphincter muscle and the rectum*" (the italics are Dr. Wing's) "of course always demand operative measures" prompts me to relate a case which happened in my own practice. June 17, 1877, I attended a little lady in her first labor. I say advisedly a *little* lady, as her normal weight was but eighty pounds. Although of such diminutive size, she was plump, admirably proportioned, a little model of perfect womanhood. The head had for some time lain low in the excavation; the perinæum was fully distended, but the vulva refused to dilate. I applied my forceps, and just as the head was emerging from the outlet she suddenly threw up the pelvis (thus altering the line of traction), the thin distended tissues gave way, and a fearful laceration was the result. Perineal resistance was so completely done away with that not only the head, but the whole body of the child, as it were, *dropped* out. The child weighed nine pounds and four ounces. Not only was the perinæum torn throughout its whole extent, but also the sphincter ani, and the rent extended fully two inches up the rectum, causing very profuse hæmorrhage from the hæmorrhoidal veins. I frankly told the patient and her husband what had happened; explained to them the nature of the injury and its extent, and that at some future time it would necessitate a surgical operation. So perfectly was all control of the bowels lost that for many days when she would have a passage from the bowels, so hard that it could be taken up in the fingers, the first intimation she would have of its presence would be by the scent. The injury was of such extent I deemed anything short of an operative procedure utterly useless, and so did absolutely nothing, save directing the nurse to keep the wound clean. I did not even tie her knees together. To my surprise and delight the wound soon filled with healthy granulations, and in less than two months it was perfectly healed, the normal action of the sphincter restored, and the woman as well as ever. May 10, 1878, I again attended her in confinement, when, after an easy labor and without the slightest difficulty, she gave birth to a child weighing nine pounds and twelve ounces. Scarcely any trace of cicatrix from the laceration could be discovered. T. C. WALLACE, M. D.

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