

SOME GYNECOLOGICAL IMPRESSIONS RESID- UAL FROM THREE DECADES OF GEN- ERAL PRACTICE.

BY WALLACE A. BRIGGS, M. D., SACRAMENTO.

"He must be a born leader or misleader of men," remarks Lowell in his essay on Democracy, "or must be sent into the world unfurnished with that modulating and restraining balance-wheel which we call a sense of humor, who, in old age, has as strong a confidence in his opinions and in the necessity of bringing the universe into conformity with them, as he had in youth. In a world the very condition of whose being is that it should be in perpetual flux, where all seems mirage, and the one abiding thing is the effort to distinguish realities from appearances, the elderly man must be indeed of a singularly tough and valid fiber who is certain that he has any clarified residuum of experience, any assured verdict of reflection, that deserves to be called an opinion, or who, even if he had, feels that he is justified in holding mankind by the button while he is expounding it."

Notwithstanding the poet's playful admonition, we may well remember that were we, in any science or in any art, to await the final opinion, perfect in fact and form, silence universal and primeval would reign forever. Emboldened, then, by the reflection that the confusion of tongues, even in medicine, is by no means the greatest disaster that could befall our society, and, mayhap, not less by a rash enthusiasm perchance abnormally surviving the human equinox, I shall invite you, to-day, not to "green fields and pastures new," but to some of the granaries of our reputed science, where the weevil so often and so nimbly plays us sad havoc.

It is my first impression that the specialist in gynecology is an evil—sometimes necessary; an evil because the narrowness of the specialist and the superficiality of the general practitioner are too often but obverse or complementary expressions of the same vice; necessary because, notwithstanding a con-

scientious struggle to attain the ideal, the general practitioner, in the vast majority of cases, lacks and very likely always will lack the severe training and the large experience indispensable in dealing successfully with the major difficulties of pelvic surgery.

The prevention and early management of gynecological diseases usually fall to the lot of the family physician, who may or may not operate, depending on his qualifications, but who must be prepared to exercise an efficient prophylaxis and to advise a timely intervention. Let the family physician then deepen his studies, and the specialist broaden his own, and specialism will be largely shorn of its evils.

It is my impression that the general practitioner is, in no small degree, responsible for the existence of the gynecologist. He is responsible because of his disregard of the developmental period. If I may trust a very positive impression not founded on actual statistical research, imperfect development of the female organs of generation, as evidenced by defective function in both the pregnant and non-pregnant state, is far more frequent than it was thirty years ago. This is the result of abnormal conditions, which are within the power and the province of the physician to correct. He is responsible because of his neglect, in labor and abortion, of well-established principles of asepsis. Without exaggeration it may be said, I think, that not one physician in ten enforces these principles in the puerperal state. He is responsible also because he too often neglects the traumatisms and milder infections of the puerperal period. Reputable physicians not infrequently aver that lacerations never occur in their practice. Within the past two years I have repaired two lacerations of the perineum, extending well up the rectum, whose existence was denied by the physicians in charge of the preceding labors. The physician is responsible also because he fails to exert his influence in the promotion of sexual morality. That gonorrhea is one of the most important causes of the surgical diseases of women is unquestionable, and yet how generally does our profession treat illicit intercourse as a venial error? Lastly, he is responsible because he fails to use the full weight of his influence in the suppression of crim-

inal abortion, whether perpetrated by "regulars" or by "irregulars."

Seventy-five per cent of the serious diseases of women can be prevented by the intelligent and conscientious application of the knowledge we now possess. How may the physician contribute to this result?

1. By promulgating and, as far as possible, enforcing the hygiene of the developmental period,—an out-of-door life; cleanliness, fresh air, and sunshine within doors; rational diet and clothing, and the timely recognition and treatment of abnormal tendencies; and, lastly, by the judicious supervision of school life, including the curriculum.

2. By insisting, as far as possible, on the employment in labor and lying-in of competent, trained obstetric nurses.

3. By the strict enforcement of asepsis in labor and lying-in. This includes the same precautions in the preparation of the patient and her surroundings, and in the conduct of labor and lying-in, as should be taken in the corresponding details of an abdominal operation. Without in the least undervaluing other precautions, there are two or three to which I desire to call especial attention.

In the first place, rubber gloves are absolutely indispensable in the practice of obstetrics, at least by the general practitioner. On this point I desire to speak emphatically and positively. *Aseptic obstetrics in general practice are certainly impracticable without rubber gloves.* On the score of economy, I have used, in a few cases during the past three years, the lightest kitchen gloves obtainable. They diminish tactile sensibility somewhat more than surgical gloves, but ordinarily they permit easy recognition of the sutures and fontanelles. They are more easily put on and off than surgical gloves, and are far more durable.

In the second place, digital examination per vaginam, whether with or without gloves, should be as infrequent as conditions permit. In three cases out of four I am content with the information derived from external palpation and auscultation. I am convinced this has been in the interest of my patients.

Lastly, the possibility of infection by the colon bacillus is

not sufficiently apprehended by physicians generally. Frequently women in labor immerse themselves, as it were, in a feather bed or inferior spring mattress, and in their uneasy movements, infect the genitals from the bedding soiled with fecal matter even before the arrival of the physician. The fetal head, advancing and receding with pain and interval respectively, carries the colon bacillus into the vagina, and not impossibly even into the uterus. Observation convinces me that this is often the mechanism of puerperal infection, assisted occasionally by the index finger of the obstetrician. A firm bed, careful local disinfection, and the utmost cleanliness are necessary to obviate this danger.

4. By immediate repair, under the strictest precautions, of lacerations of the genital tract. I can see no reason why lacerations of the cervix should form an exception to the rule. Undoubtedly, like every other innovation, this will meet the inertia of professional opinion and practice, but, with improved technic, it will be as firmly established as immediate repair of the perineum, allowing, of course, for the natural tendency of mankind to ignore unpleasant things which do not positively thrust themselves on the attention.

5. By immediate and thorough treatment of puerperal infection, whether early or late, mild or severe. In communications to the *Occidental Medical Times* and the *American Gynecological and Obstetrical Journal*, I have described a method of abortive treatment which has proved extremely efficient. These cases should be followed up vigorously in the early period, and not be permitted to drift on into the hands of the gynecologist.

6. By the promotion of sexual morality. Too often encouraged by physicians, the impression prevails among young men that continence is incompatible with sexual health. Whatever view he may adopt in this regard, no intelligent physician can for a moment doubt that the evils of incontinence, both individual and social, are a thousand-fold greater than those of continence. Whoever has stood by the bedside of a young, innocent, and trusting wife, dying of gonorrheal peritonitis, or has witnessed the loathsome ravages of syphilis, either hereditary or innocently acquired, must needs be ethically

moribund not to exert his influence in the suppression of sexual vice.

7. By the discouragement of infanticide *in utero*. This we may do in several ways: By refusing professional recognition medical men engaged in abortion; by educating public opinion; by refusing to sign death certificates in cases of death due to criminal abortion, and thus bringing about a judicial investigation. It is my impression that the envisagement of salpingitis as an exclusively surgical disease is by no means free from objection. The surgeon who would stand aghast at the suggestion of sacrificing the testicle for a gonorrheal epidymitis, removes the gonorrheal tube in perfectly cold blood. Of course, this parallel is not perfect; no parallels are, except in imagination; but a not inconsiderable experience convinces me that the latter disease, uncomplicated, in the early stages, may be cured in the majority of cases without recourse to surgery. Observe I say in the early stages of a majority of uncomplicated cases. Were I to say in practically all uncomplicated cases, I should be unconscious of exaggeration. Every case of gonorrhea in women should be treated vigorously from the very beginning, in order to prevent extension to the uterus and tubes, both of the gonorrheal and of any secondary infection. The patient should be put to bed, the vulva cleansed, the urethra and vagina irrigated with potassium permanganate solution (1:4000 to 1:2000), and a 10 per cent protargol glycerin tampon placed against the cervix and another just in the vaginal orifice, covering the mouths of the urethra and Bartholin's glands. The latter tampon should be removed before each urination, and replaced by a fresh one immediately after. The douche and cervical tampon should be repeated three times a day. If infection have already reached the tubes, the same treatment should be instituted, with the addition of saline laxatives and the ice coil to the lower abdomen. The saline laxatives should be continued until the acute symptoms have subsided and the likelihood of general peritonitis is past; rest in bed until convalescence is firmly established, generally from four to eight weeks, and the douches and tampons until the disease is eradicated. At the first intimation of peritonitis

give a saline laxative, apply the ice coil to the abdomen, and stop feeding by the mouth entirely; nourish by the colon, carefully washing out thoroughly once a day. Continue this treatment until convalescence is established,—usually from twelve to twenty-four days. Begin with stomach feeding, tentatively, and suspend it at once if not well borne.

Within the last eight years I have pursued this plan of treatment in four cases of general gonorrheal peritonitis, two of them having stercoraceous vomiting (one of them on coming under my charge), and all recovering completely. One of them has since borne a child.

It is my impression that, under the influence of aggressive and triumphant abdominal surgery, the vaginal vault, as an approach to pelvic disease, has fallen into unmerited disfavor. **As one of those who, in suitable cases, have steadfastly adhered to the latter during all its vicissitudes, and yet have no superstitious dread of the abdominal peritoneum, I have some opinions sufficiently grounded in experience to warrant their expression. Comparing abdominal with vaginal approach to the pelvis, these impressions are:—**

1. No physician who has had sufficient experience with both of these methods will abandon either one. Each has its field,—not always clearly defined, but usually determinable.

2. In pelvic disease vaginal is preferable to abdominal approach: (a) In puerperal infections and acute infections generally (in the early stages of these troubles drainage is often all that should be attempted, and the cases in which this should be premeditated by the abdomen are of extreme rarity); (b) in acute pyosalpinx, single or double; (c) in suppurative pelvic peritonitis and cellulitis; (d) in infected pelvic hematocele; (e) in old pelvic hematocele with delayed absorption; (f) in selected cases of misplaced pregnancy, either before or after rupture or abortion; (g) in small fibroids demanding hysterectomy; and (h) in incipient cancer of the uterus.

It is my impression that the desuetude into which the solid silver nitrate has fallen in the treatment of cervical catarrh and abrasion is not by any means innocuous. For a time, in obedience to authoritative professional opinion, I abandoned

the solid stick for other and less efficient means, but soon returned to it, and, as the result of considerable experience, believe that the general prejudice against it is unfounded. In ordinary abrasions, due to slight or moderate laceration and cervical catarrh, the solid nitrate (in senile abrasions conjoined with acid nitrate of mercury solution) is one of the most efficient remedies—not, of course, to the exclusion of curettement in proper cases. The organic silver salts may possibly do as well as the stick nitrate, but the latter, in contact with the secretions, is immediately decomposed, and forms an organic salt in more intimate contact with the diseased tissues than it could possibly be brought by any other means.

It is my impression that, in the diagnosis and treatment of diseases of the urethra and bladder in women, the endoscope is too often ignored. Without it differential diagnosis and rational treatment in these diseases are impossible. Kelly's recent modification of his original instrument is based on scientific principles, and leaves little to be desired.

It is my impression that misplaced pregnancy is frequently unrecognized in general practice. In the past twenty-two years I have seen eighteen cases of this anomaly, nine in my personal work and nine in consultation. As all but two of these (one each in my personal and my consultation work) occurred in the latter half of this period, it would not be unnatural to infer that several had been overlooked in my earlier experience. Disregarding this indefinite number of presumptive cases, however, there still stand accredited to me personally nine cases of misplaced pregnancy, constituting, as I reported to the Sacramento Society for Medical Improvement, a ratio of not less than 1:250 of my obstetric cases. This is about double the ratio ordinarily given, which, without ascribing great importance to a limited and individual experience, I am yet inclined to believe is below the mark. I am of this opinion for several reasons: 1. The recognized cases of ectopic pregnancy in my own obstetric practice have exceeded a ratio of 1:250, which I suspect would be materially increased by the unrecognized cases of the earlier, and possibly even of the later, period. 2. The recognized cases seen in my personal and consultation work in the city of Sacra-

mento constitute an estimated ratio of misplaced to normal pregnancy of not less than 1:750 for the entire city. It is far from probable that, during a period of twenty-two years, any one physician has seen two-thirds of all the cases of ectopic gestation occurring in a city of an average population of 22,000 or 23,000. 3. All of the cases of misplaced pregnancy recognized during this period in the city of Sacramento, as far as I have been able to learn, have occurred in the practice of four or five physicians. It is highly improbable that the twenty or twenty-five others in equally active practice have on the average escaped the normal ratio of these cases. 4. Until quite recently physicians generally have regarded tubal rupture, with its classical features of sudden excruciating pelvic pain followed by exsanguination and collapse, as the logical and necessary outcome of tubal pregnancy. With such views they could not escape ignoring a large ratio of cases.

DISCUSSION.

Dr. Geo. B. Somers, San Francisco: The paper that has been offered comprises gynecological experiences of the last two or three decades. The last twenty-five or thirty years represent the time that it has taken gynecology to reach its position as an independent specialty. As far as my own experience goes, it does not cover one decade, but all those who are interested in gynecology must know the problems the pioneers had to contend with. The first thing that strikes us is that attention was first directed to topical treatment of the diseases of women. This constituted the entire scope of gynecology, and nothing was done for treatment except the use of strong astringents and cauterizing agents. In this time, between 1870 and 1880, silver nitrate, caustic potash, and nitric acid were frequently used, and Emmett's attention to the bad effects due to the use of these strong agents lead him to work out many of the principles and practices of gynecology. Dr. Briggs, in his paper, called attention to the use of the silver nitrate stick, or lunar caustic, as a valuable remedy, stating at the same time that it had fallen into disuse. I think most of us feel that the disuse of these strong

agents in local application is based on the results of the ill effects following their use. We know well that the whole of the uterine cavity is filled with glands, which are likely to be obstructed and destroyed by the use of strong applications. Dr. Briggs said a word or so about gynecology as a specialty, and said, I believe, that his impression was that it is an evil, perhaps a necessary evil, and based his impression on the fact that many of the conditions in gynecology found their way to the hands of the gynecologists through neglect in the treatment of parturient women. This must be considered as a fact, but a better future in this respect has been prophesied. The qualifications of physicians nowadays, with their four years of study and service in the hospitals, lead to a thorough appreciation of asepsis and sepsis; and when they realize that the scrapings from the fingers, even after the hands have been well cleansed, develop many colonies of staphylococci or streptococci, they appreciate the importance of this subject. The interior of the uterus is a most favorable place for the development of septic germs, and it is a wonder to me that we do not get very much more of it. In reference to prophylaxis, I think Dr. Brown's plan of using rubber gloves is an excellent one in the examination of parturient women. No one would attempt to confine a woman without aseptic precautions, and when we realize how easily septic media are introduced into the uterus, I think the use of rubber gloves must appeal to every one. Another point was read by Dr. Briggs and Dr. Brown, in reference to the repair of the cervix and perineum after confinement. There is no question in reference to the necessity in performing the operation after a tear of the perineum; but as for the cervix, there is some room for doubt as to advisability of operation, unless the injury is of considerable extent. It is a most difficult thing to get the patient into a condition to operate after a confinement. As to the repair of the cervix, it is a serious operation in the parturient, since the parts are open to sepsis, and we add an additional element of danger by operating. There are cases where it must be repaired, and the main indication of this is hemorrhage. If hemorrhage does not take place, and if it is not badly lacerated, the parts will heal sufficiently, or we may

perform the operation later. Dr. Brown's point in reference to examination at stated periods after parturition, is an excellent one. For one thing, it enables us to protect ourselves, for we save our patients from falling into the hands of the unscrupulous, who may cast the odium of laceration on the attending physician. I am glad to hear Dr. Davis call attention to the use of the pessary, and feel myself that it is an agent for the greatest good in many cases. Where indications for operations like the Alexander seem to be present, where there are no complications, the careful and judicious use of the pessary will obviate an operation. Alexander's, by the way, is an operation having many admirers, but often followed by serious results. I know of a number of cases of ectopic gestation where the vaginal route was followed; still if we have 100 successive successful cases by the vaginal route, that would not be enough evidence to exclude the abdominal route. We must take the abdominal route in some cases, more particularly where the tube has burst. Only recently I found it necessary to use the two routes. The case was a woman living in a country town, seven or eight miles from Carson City. The pelvic cavity was filled with a fluctuating tumor of ectopic gestation. Evidently the sac was full of blood. This had to be removed. The sac was opened through the vagina, in order to relieve the tension and to prevent the bursting of the sac into the abdomen. In the examination, at the time, it became perfectly evident that the placenta could not safely be delivered through the vagina in this particular case. The cavity was packed with iodoform gauze, and the patient shipped to the city, and put into proper quarters, where the abdominal route was subsequently followed. There are a number of other very interesting points to be considered, but I will not occupy any further time.