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GYNAECOLOGICAL PRACTICE IN CHINA.*

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The treatment of women's diseases is certainly attended with difficulty, first because many patients object to vaginal examination, though this is not so great a difficulty as formerly, but even now many prefer to do without treatment rather than be examined; another difficulty is that the patients want symptoms cured rather than disease; the cure of the disease being often too radical a measure for them.

Of symptoms, as far as my observation goes, dysmenorrhœa and dragging down pains are *not* common, but amenorrhœa, too frequent menstruation, rectal and sacral pains, and leucorrhœa, this last especially in elderly women, one is consulted about constantly, and on examination one often finds nothing abnormal to account for the trouble. A married woman of 22 was sent to me for examination. She had never menstruated, nothing abnormal could be found to account for it, the uterus was not small, and she was not markedly anæmic. She was given an iron and arsenic tonic, of which she may have taken three or four bottles, and within a few months was menstruating regularly. Possibly marriage wakened up her dormant uterus.

EXTERNAL DISEASES.

External diseases of vulva and vagina constitute a large percentage of our cases—vulvitis of every type, venereal warts, abscess of Bartolin's gland, erosion of the os, and leucorrhœa, with occasionally an external new growth. One such case was interesting on account of the size of the tumour. The notes of the case are as follows:—

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Mrs. Ts'un, widow, 46. Fibroma.—The patient is a strong woman, who has always had good health. There is a pedunculated tumour hanging from the right labia to below the knees; it is hard, lobulated, and freely moveable. Length 19 inches, width 15 inches. Skin is lax and free from inflammation; inguinal glands are not involved, and the patient looks well. Chloroform was given and the tumour dissected out of a three-inch incision. The tumour weighed 12¾ lbs. and was a fibroma.

UTERINE DISEASES.

(a). *Of inflammations*, endometritis is often met with, and usually yields successfully to treatment. Even in this condition dysmenorrhœa is not often complained of, though one has seen membrane passed in form almost a complete cast of the uterus. Curetting is rather fashionable with us just now, as some patients have given birth to children after the operation; the improved condition of the uterus allowing them to carry the child to term.

(b). *Uterine displacements*.—Of these prolapse is the most common, and this is easy to understand when one remembers Chinese methods of delivery, the sitting posture with exhausting bearing down efforts of the patient, the method used of a woman sitting behind with her arms round the patient forcing down the uterus, and finally the awful plan of pulling on the cord to remove a retained placenta. On several occasions, when called to remove a retained placenta, one has found the woman sitting up, with the anterior vaginal wall and cervix outside the vulva and the midwife *still vigorously pulling on the cord*. Some of these cases, if treated at once by the replacing of the organ, and after by the use of a pessary, ultimately recover. But others who do not get foreign treatment, often go on for years with complete prolapsus uteri. Last year a woman of 50 came to dispensary who had had complete prolapsus for twenty years. She came not to get the prolapsus cured, but to get an ulcer which had formed on the extruded part healed. She absolutely refused all treatment but a lotion. Rest, pessary, operation, were all scorned, and so she gained nothing.

Several cases have been cured by the use of a ring pessary and anterior colporrhaphy. This is a simple proceeding, and does not cause so much narrowing of the vagina as posterior colporrhaphy, which is a consideration, as many of these patients are at the child-bearing period of life. The operation of anterior colporrhaphy consists in dissecting off a piece of the mucous membrane of the anterior vaginal wall and bringing the sides of the raw surface together with stitches. The shape is not very important, but an oval dissection, with the long axis of the oval parallel to the long axis of the vagina, is best, as the object is to narrow the outlet of the vagina.

The use of a pessary is a very debateable point in China. Even in large cities at home, patients are often careless about coming to have them cleaned. I remember digging out something that felt like a stone from a woman's vagina in Dublin. It was a ring pessary that she had worn for two years, and was thickly encrusted and was very difficult to remove, being buried in the tissue about it. In China one ought to be careful, I think, not to use a pessary unless one can, if necessary, send for the patient if she fails to put in an appearance for herself.

Other displacements are rare. A few cases of retroflexion and retroversion come to mind, but nearly always it was in connection with a gravid uterus, and one was sent for because of retention of urine.

(c.) *New growths of the uterus* are common, but those one is called upon to treat are usually malignant. Fibroids rarely come to one's notice. Polypi, with long pedicles, are more frequently under one's care, because sometimes they can be seen, or excessive bleeding is caused by them during labour. But on the whole these are not considered serious enough for the patient to consent to operation, and she will only swallow drugs when troubled with hæmorrhage.

Cases of cancer and sarcoma of the cervix and also of the body of the uterus, very frequently come for help, but as a rule *too late* for operation. The refinements of early diagnosis of uterine or cervical cancer are usually not required. As a rule the smell of the patient as she walks into the room is sufficient to indicate the disease, and also its advanced condition. I have never yet managed to persuade a case suitable for operation to have amputation of the uterus, and so have had only palliative measures to resort to.

INJURIES.

Injuries during child-birth are very common, and a good many cases come to get these injuries repaired. Rupture of the perinæum is common everywhere, but here nearly every woman one examines has a ruptured perinæum. Unless unusually severe, I do not think any Chinese woman would consent to have an operation for it, as it seems to cause them very little, if any, inconvenience.

Another result of tear is, however, more serious to them, and calls for treatment. That is when the tear heals by granulation, occluding the vagina and causing atresia vagina. I remember several cases where there was a complete septum joining the two labia. This was divided, and the vagina not being implicated, the parts healed and there was no further trouble.

Another case had but a pinhole opening which it took some time to find. It was gradually dilated with probes and sinus forceps until it was of a size to admit a finger. Incisions were then made on both sides, cutting towards the tuber ischii and a glass speculum inserted. One must keep in a plug and make a large opening, as the parts contract down again, the contraction going on for a month or six weeks after operation.

One case of congenital atresia vagina comes to my mind.

Mrs. L., aged 19. Her mother came to say that her daughter was "the Bride of Heaven," but as she was newly married they wished her to become an ordinary woman. Patient has been married three months, and is subject to fever. Complaints of abdominal pain, and has never menstruated. Great pain every month. The abdomen on inspection is tense and large. There is resonance in both flanks, and just above the brim of the pelvis is a central globular swelling. Dullness and tenderness on pressure over the pelvis. Shape of vagina is externally natural. No bulging of the hymen. There is not the slightest opening into the vagina. *Per Rectum.* A mass, rounded, globular, hard and tense, and fairly moveable, can be felt within $1\frac{1}{2}$ to 2 inches of anus. Apparently a complete septum between the vagina and the uterus.

A false vagina was made, and the knife being plunged into the sac, the usual treacly fluid evacuated. There was a little subsequent fever due to parasites, but the patient recovered and menstruated regularly for years, and was to some extent able to fulfil her functions as a married woman.

Tears and sloughs of bladder and urethra are common results of Chinese midwifery, so one gets a good many cases of vesico-vaginal and urethro-vaginal fistula leading to incontinence. When a fistula has formed by sloughing from pressure, there is not incontinence until the slough separates, and as it is more often the result of pressure than of direct injury from muscular effort, the usual history is of long and difficult labour, and about a week later incontinence. The diagnosis is made by physical examination by exposing the vagina with a speculum.

The curative treatment of a fistula is a plastic operation. It is best to wait some time—six weeks to three months after parturition—as the tear may close spontaneously, and also because involution ought to be complete, and so the tissues be firmer and less vascular.

OVARIAN CYST.

No lady medical can be long in China without meeting another class of case—that of ovarian cyst. Ovaritis is not often complained of, and perhaps cystic ovaries are not really so common, but their size impresses them firmly on one's mind. Every year one meets three or four such cases, but only an occasional one—say one out of five—is

willing for operation. The only ones that have consented to operation during my charge have had cystic parovarium, and one had a solid ovarian tumour. It has certainly been a case of gathering experience little by little. It is hardly necessary for me to go over the steps of the operation to such an assembly, and I will content myself by giving two cases and raising an important question for discussion.

In the general teaching of the home operators, tapping the cyst previous to removing it is strongly condemned. But these very large cysts with which one has to deal in China, cysts that displace the heart, would it not be better, in such cases, to empty the cyst at one time, sew the cyst wall to the abdominal wall and remove the cyst in a couple of days? This question is asked because it has occurred to some of us that death, said to be due to shock, is due rather to the vast mass of fluid and tumour taken away; than to ordinary shock following operation, no satisfactory reason being otherwise found for death in some cases. Below are described two cases, both alike in many particulars. Why did the first one recover and the second one die? In both cases the operator was the same.

CASE 1, 1900.—Mrs. Hsiung, aged 21, married, seems cheerful and happy, but is a very thin woman. From the time she was a young girl the patient thinks the abdomen was enlarged. Menstruation regular in time, scanty in amount, very dark in colour and associated with dysmenorrhœa. Has been married four years, has one child a year old. During pregnancy abdomen enlarged very rapidly, and has since grown a good deal. No menstruation since. Weight of patient, 176½ lbs. The abdomen is much distended, with enlarged surface veins; umbilicus flush with surface. Dulness over the tumour and resonance in both flanks. Circumference at the umbilicus fifty-four inches.

At the operation, which lasted two and a half hours, the only adhesions were to the anterior abdominal wall and to a small piece of bowel. There was fever ranging from 99 F. to 102 F., and several lumbricoids were voided. The wound healed by first intention, and the patient's weight a month later, when she had put on a great deal of flesh, was 95½ pounds. The tumour must therefore have weighed between 80 and 100 lbs.

CASE 2, 1905.—Mrs. Li, aged 21, married. The patient has had a hard life, with heavy work and many beatings from her mother-in-law. Commenced to menstruate at 16; after a year it became scanty and dark in colour; has ceased for two years. About five years ago she noticed a small swelling on the left side, and this gradually increased in size. Last year had a "bad attack of abdominal pain," probably peritonitis, and nearly died. Occasionally faints. Patient looks older than her years, is thin and emaciated and eats very little. Abdomen is universally distended, but in the left lumbar region there is a daughter cyst. Girth at umbilicus is 51 inches; 6 inches above it is 52 inches.

P. V.—Os is smooth and small. Uterus small and to right; ovaries cannot be felt; uterus apparently not adherent. Tumour is on left side. Heart is displaced

upwards to third interspace, and there is venous congestion over the chest and abdomen. Aortic sound is *not* pure, though there is no distinct murmur. Sometimes pulse misses a beat.

The operation lasted one and a half hours. There were adhesions to the anterior abdominal wall; these were peeled off with a gauze pad; adhesions to omentum were plentiful; these were tied, outside the abdomen, and cut through. There was very little bleeding throughout the operation, but some ascites. Four ligatures were placed on the pedicle, as it was very thick. The patient's pulse at the close of the operation was 84. She was put back to bed under the care of two very competent nurses; she soon recovered consciousness, and recognised the nurses, but was not really clear in mind. Pulse was 100. Seemed thirsty and restless, and hot water was given in spoonfuls by the mouth, and saline injections into rectum, and subcutaneous injection into axilla. Pulse improved. About 4½ hours after operation the patient suddenly fainted. I was on the spot at once, but she could not be restored. The abdomen was opened at once, but the pedicle was not bleeding. One could only say "death from heart failure"—but why? Would she have recovered if we had first removed the bulk of the fluid? This question has often presented itself since the operation, and I should be glad to receive the opinion of the Conference on the point.