THE PROPRIETY OF OPERATIVE MEASURES IN PELVIC PERITONITIS.

Read before the Section of Obstetrics and Diseases of Women, at the Forty-fourth Annual Meeting of the American Medical Association.

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Operative interference has become so frequent in pelvic and abdominal troubles that at a casual glance it would seem that nothing had escaped, and that a paper calling attention to any one of the numerous pelvic affections would be superfluous; that all conditions for which operations were advised and practiced were fully understood; that the time for operative interference was definitely settled, and that every community had had an operation or two of this character. A more careful observation, however, will show that neither of these points are settled and without their settlement the status of operative interference is yet a debatable question.

We have arrayed on the one side the conservatives with conservatism carried to timidity. On the other, we have the reckless and amateur operators, of whom the latter are the more dangerous, not alone on account of their inexperience, but in their anxiety to become abdominal surgeons they open abdomens upon the slightest pretext.

Occasionally they may do good, but more frequently harm is the result. Cases of pelvic peritonitis differ in their effects but little from general peritonitis, save in degree and the liability to the formation of abscesses. In this respect they more closely resemble localized abdominal or circumscribed peritonitis. All occur as a result of a cause; none are idiopathic. All are affections, either primarily or secondarily, of the same extensive membrane which lines abdominal and pelvic cavities, and are accompanied by practically the same symptoms and run the same course. When moderate in degree they recover spontaneously, or with little or no treatment, and that of the simplest character, such as rest, diet and simple remedies.

Occasionally, like all other inflammatory disorders, spontaneous cure may result or, technically, resolution may occur; again, the effused lymph may become organized, and after the subsidence of the inflammation important organs may be greatly hindered in the performance of their proper functions on account of the faulty positions which the adhesions cause them to assume. Of the uterus and the ovaries this is especially true; the rectum and bladder also becoming involved. Repeated attacks increase the difficulties already named, and the consequent irritation and pain soon affect the whole nervous system; the patient becomes a wreck frequently in a comparatively short time.

In the class of cases above enumerated there can be little doubt that most intelligent medical men, as well as gynecologists, would advise an operation.

But it is not in this class of cases that difficulties are experienced in determining the course to pursue. The repeated attacks have given abundance of time for observation and reflection, as well as fair opportunity to test every known remedy.

It is in an acute case that the skill of the diagnostician and therapist are put to the crucial test. It is in these cases that the profession are most in need of definite rules of procedure. It is here that the prognosis is most difficult.

The peritoneal investment of a single organ may be involved as a result of a general inflammation of that organ, and this limitation may prevail throughout the course of the disease. Again, the entire pelvic peritoneal investment may be speedily involved. An inflamed uterus, a salpingitis, an ovaritis or a septic condition may prove the initial point of infection. The virulence of the inflammation may be such as to render differential diagnosis difficult or impossible.

If the formation of an abscess or a pus cavity can be made out, the rule to evacuate is imperative, but do we not wait frequently longer than is necessary for the plain indications of purulent deposits? The pointing in the direction of least resistance may not be discoverable until too late. The peritoneal cavity or the alimentary tract may receive the collection while we wait. This has occurred so often that there are none of you but who could recall lamentable instances of its occurrence.

Pyosalpinx, a not infrequent cause of pelvic peritonitis though not so easily discoverable, frequently on account of the small amount of contained pus, is another cause which demands operative measures for the reason that all else is futile. Curetting and packing with gauze the cavity of the uterus is not of itself free from danger, and is certainly not effective. The dislodgment of the pus producing germ cannot be effected in that way, although it may be said to be to a certain extent an operative procedure, yet it is one from which I have failed to secure the desired results.

Inflamed, degenerated and broken down ovaries are beyond restoration; they are not only useless but a source of danger while they remain; they are to a certain extent foreign bodies; no remedies can effect their reorganization or prevent the inflammatory conditions which they excite.

That the patient may survive many attacks of this kind is not to be questioned. The question is, however, as to the advisability of permitting a patient to experience the danger and hazards that are always present in severe cases. The disease in the male analogous to pelvic peritonitis is appendicitis. A patient having experienced one attack is almost certain of a recurrence; some light, others severe in character. As to the danger to life and the inability to determine the gravity of an impending attack, there is no difference of opinion.

Since operations have been more frequently performed, the opportunity for study of the pathology has been greatly enhanced. The terms, typhlitis and perityphlitis, and other unmeaning phrases have been discarded. The diseased organ has been discovered and the remedy applied, which to-day is operative interference, not only during an exacerbation but frequently after an attack has subsided, when apparently all functions have been resumed and to all outward appearances no disease exists.

That skilled surgeons would advise an operation when the presence of disease cannot be demonstrated by objective symptoms, would be one of the unaccountable mysteries of surgery, were it not that pathology and experience have taught us that recurrences are certain and that the interval of quietude offers advantages that both surgeon and patient should not allow to pass.

Early removals of offending organs in pelvic peritonitis are no more dangerous than in appendicitis;

the same immunity is secured, and years of pain, suffering and invalidism are avoided. Without it, localized inflammatory deposits may exist for years, their presence always manifest in some degree at least, susceptible of breaking forth at any time with great violence. If the patients be fortunate enough to escape death they frequently undergo such an amount of suffering that death may almost seem preferable.

I have recently dealt with two cases of this character. For several years repeated inflammations have occurred; neither of them had seen a well day for at least three years; both had been repeatedly confined to the bed,—one for fourteen weeks. At the end of that time she had practically made her usual recovery,—a recovery that was far from complete. Knowing from experience the certainty of recurrence she readily consented to an operation, and while the difficulties of an operation at this time were far greater than they would have been at an earlier date, the recovery was prompt and relief is complete. The second had the same history except none of the attacks had lasted so long. So intense, however, was the last one that life was despaired of at the end of two weeks. Operation was the only alternative; no preparation of the patient could be made for the want of time. The result, however, was all that could be desired. In the earlier years of my practice when operations of this kind were viewed unfavorably by the profession, I have seen many patients lost who would now be saved.

I do not wish to be understood as advocating the propriety of operative interference in all cases. Many cases apparently recover completely and patients continue to enjoy perfect health. Slight pelvic inflammations are not always dangerous, and if they do not become chronic are not seriously inimical to health and comfort.

In these cases the dangers of an operation should not be undergone; other and less hazardous measures will afford equally complete relief.

If you will bear with me for a few moments I will endeavor to formulate a rule or two for time of operations and the class of cases to which they are applicable.

The decision as to the propriety of operative measures and the time when they should be resorted to are frequently beset with greatest difficulties, and the only rule in acute cases that seems to me to apply at all generally is one laid down by some one in intestinal surgery. As soon as it is apparent that other means will be of no avail, the time for operative interference admits of no delay.

In chronic cases, or cases with frequent recurrences, or chronic cases as regards time and acute with regard to symptoms, there are two periods when operation is justifiable. The first, when life is endangered during a recurrence. The second, after the subsidence of an acute exacerbation. This I regard as the preferable period, but unfortunately it cannot be always secured, first for the reason that the acute stage may demand relief; secondly, the patient frequently refuses the tender of relief of this character while the suffering is not intense. Under this head may be included all those cases of encysted collections of pus, gonorrheal, or otherwise, tubal collections of whatever character. Diseased and degenerated ovaries, adhesions which give the semblance of tumors by the distortion of the pelvic organs, and

the consequent impairment of their functions, as well as all mental and nervous disorders that are directly traceable to disease of the pelvic organs.

ACCOUCHEMENT FORCÉ IN CERTAIN OBSTETRICAL COMPLICATIONS.

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Accouchement forcé, is as we understand it, a labor actively begun and terminated by artificial aid. This assistance may be rendered through mechanical devices, such as Hegar's and other dilators, Barnes' bags, forceps, catheters, sounds, tampons of cotton or wool, sponge tents, or by the hand introduced into the vagina with the fingers acting as dilators. It is our opinion the fingers are the best and safest means of assistance for the reason that the force exerted is active, appreciative and entirely under the control of the operator. The dilation may be rapid or slow, strong enough to produce a laceration of the cervix and body of the uterus, as in the case related by Parrish at the meeting of the American Gynecological Society in 1892, when discussing this subject, where the hand introduced after delivery reached the bifurcation of the aorta but surely this accident must be among the rarest of obstetric novelties. The hand is soft, it appreciates the degrees of dilation effected, it can detect the softening of a rigid os, it can recognize the tearing of a cervix and it can preserve the membranes intact. These advantages can not be claimed by any of the mechanical devices commonly employed; not one of them will afford us any positive information as to the amount of harm that is being done; they only tell us we have dilated sufficiently to require a dilator of a larger size or that we may introduce another and still another alongside of the first; they simply act as any other mechanical device.

The indications which govern us in producing labor or for dilating the os and terminating labor are, placenta prævia, uremic convulsions, excessive amount of albumen in the urine accompanied by headache, dimness of vision, anasarca, general or limited, and other symptoms leading us to fear convulsions, uterine inertia, rigid os, escape of waters with inefficient pains, spasmodic contraction of the uterus. Any one of these conditions demands our assistance, but how many of us go to a case of obstetrics with forceps and all other mechanical apparatus pertaining to the correct practice of an art; indeed, how many of us are the possessors of such appliances? For one, I plead guilty to the charge of not possessing all of them. When called to a case of rigid os, or where the pains following the premature discharge of the waters are slow, useless, inefficient, why should we send for any artificial dilator when we have with us the safest and best dilator to be found, in the fingers? Are we to allow a placenta prævia case to pass slowly but surely from our hands to a certain death if not relieved, simply because our teachers of obstetrics and our textbooks do not counsel the course I advocate? How many sorrows have been scattered, how many constitutions have been shattered, how many happy homes broken up, how many useful and talented women have gone to their untimely graves through this blind following