Treatment of Malignant Growths

DR. RUSSELL H. BOGGS, Pittsburgh, Pa.: The degree of malignancy varies with the lymph supply of that part of the body in which a cancer is situated. The richer the lymph supply, the greater the degree of malignancy. When properly applied, Roentgen irradiation diminishes the permeability of the lymph vessels, and reduces the possibility of metastasis occurring as well as preventing, in large measure, a recurrence. If the treatment is given before operation, an inoperable case may be converted into an operable one. Every malignant growth presents a separate and distinct problem which demands for its solution consistent team work on the part of the patient and the operator. The improvements in surgical technic have done much to reduce the number of recurrences of cancer, but expert surgeons are not satisfied with the results obtained from surgery.

Roentgen irradiation of malignant growths must be powerful enough to destroy the neoplastic cells and to stimulate the healthy cells to resist the invasion. A small dose is useless. Small doses given for a long time really favor the development of the growth, because they stimulate, whereas they should destroy. I have treated quite a number of cases of lymphosarcoma of the neck both before and after operation. The experience gained from treatment without operation has convinced me that these tumors will usually disappear under heavy Roentgen treatment, and that the results are more permanent, if the treatment is given first without operation. In nearly every case the mass can be made to disappear, if the treatment is begun before the glandular involvement is too extensive. After the growth has entirely disappeared, a second series of radiations should be begun as soon as the skin reaction has disappeared. It may be necessary to give a third or even a fourth series of treatments. I have patients apparently well for over four years, the diagnosis having been made microscopically.

My most successful results in sarcoma have been confined chiefly to the lymph nodes. The cancer cases in which Roentgen treatment has been of the greatest service were those of involvement of the breast, cervical lymph nodes, and other external parts when internal metastasis had not taken place. Roentgen therapy should be applied to deeply seated growths, not with the idea of effecting a cure, but to check the progress of the growth and to make the patient more comfortable. Post-operative treatment should be begun immediately after the operation. The treatment must be given according to the best judgment of the roentgenologist, and not of the physician or surgeon referring the patient for treatment. Some unfavorable cases can be made favorable for operation by anteoperative treatment, and hopeless cases may be treated palliatively with great relief to the patient.

DISCUSSION

DR. GEORGE E. PFAHLER, Philadelphia: I saw a case of lymphosarcoma involving the side of the neck which was considered hopeless from every point of view. I treated the patient with the Roentgen ray in the hope that I could give some relief. Within three months the tumor had undergone cystic degeneration. I referred the patient to a surgeon, who opened the cyst and drained it of a large amount of yellowish, pus-like fluid. It was assumed that my diagnosis was wrong, that the case was one of tuberculosis. Pathologic and clinical examination, including the inoculation of guinea-pigs, failed to substantiate that assumption. In about six weeks recurrence was noted and the patient finally died of sarcoma. I merely cite the case to show what the Roentgen ray can do in these cases.

I have had cases of carcinoma in which the course was similar to that cited in the case of sarcoma. I agree with Dr. Boggs that the first treatment we have for these cases is Roentgen therapy. We must give as large a dose as possible, without producing a burn, and persist in the treatment for a long period of time. There are a large number of cases on record in which an apparent cure was obtained by Roentgen treatment, so that a cure under such conditions is by no means to be regarded as an accident.

MR. H. W. DACHTLER, Toledo: A few years ago I refused to treat any case with the Roentgen ray when I was convinced that it was perfectly useless. I find now, however, that some patients treated two years ago are apparently well, patients whom I would not have given any treatment at all had I seen them three years ago. Some surgeons now refer every case of malignant growth for Roentgen treatment immediately after the operation.

DR. P. M. HICKEY, Detroit: The results obtained by me in several cases of malignant growth have convinced me that the combined treatment of surgery and Roentgen irradiation is the proper one, and that it should be carried out whenever possible. We can now hold out more hope to the patient than was possible a few years ago.

(To be continued)

AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS

Twenty-Fifth Annual Meeting Held at Toledo, Ohio, Sept. 17-19, 1912

The President, DR. X. O. WERDER, Pittsburgh, Pa., in the Chair

Cesarean Section in Double Uterus and Double Vagina

DR. N. STONE SCOTT, Cleveland, reported the case of Mrs. A., aged 32 years, primipara, who had always had a moderate dysmenorrhea, was never very regular, never ahead of time, usually late a week or more; the menstrual period was preceded by a week of pain. She had no idea that there was an abnormality of development such as was discovered by her physician at the time of the confinement. After labor lasting three days, the attending physician discovered a septum in the vagina, with a cervix on each side of the septum, the pregnancy being on the left side. No progress was made in labor. The os was found undilated, although it easily admitted the finger. The head was high, but firmly impacted in the pelvis. The pelvic measurements were those of an equilibrio justo minor with a conjugata vera of about 9 cm.

A high cesarean section was now carried out. After the placenta and membranes had been removed, examination proved that the uterus was double, with a rupture of the septum between the two cavities. This rupture occurred at the thinnest place, in the middle of the septum, but even here it was a quarter of an inch thick. Through this rupture the false decidua were removed from the right uterine cavity, the fetus occupying the cavity on the left. The tubes were normally implanted, one at either side of the fundus. There was no cleft in the uterus itself, but a raphe running the entire length of the uterus was plainly seen at the surface.

Prior to the patient's leaving the hospital, careful examination was made to ascertain postoperative conditions. The cervix on the right side presented the features of an unimpregnated cervix; the one on the left corresponding to an ordinary cervix two weeks after delivery; it was considerably larger than the cervix on the right side, somewhat dilated, and in it was a very small lateral tear. The left vagina was possibly a trifle larger than the right, though not much. Both cervixes lay comparatively close to the median partition. On the fourteenth day following the laparotomy, mother and child went home in the best of condition.

Acute Dilatation of the Stomach

DR. CHARLES EDWARD ZIEGLER, Pittsburgh, Pa.: I report a case of acute dilatation of the stomach following cesarean section. Postural treatment and hypodermic medication appeared useless in the case. The supply of fluid was kept up by rectal and subcutaneous infusion of salt solution. Gastric lavage was the only treatment that caused any amelioration in the symptoms so far as we were able to judge. If there is one thing to be learned in the treatment of this condition from my case, it is that gastric lavage in acute dilatation of the stomach should be repeated at intervals of not less than two hours. My own feeling is that gastrostomy, with continuous irrigation of the stomach, ought to be the ideal treatment, and should be given a trial in cases which do not respond to two-hour lavage.

DISCUSSION

DR. HERMAN E. HAYD, Buffalo, N. Y.: I do not think we can put the case reported by Dr. Davis in the category of acute gastric dilatation. Unfortunately he did not have a post-mortem examination. It is possible that this woman had a dilated stomach previous to her pregnancy, and that this dilatation was in a measure hastened by the advancing or growing uterus, and just as soon as he emptied the uterus of its contents, the patient had an acute dilatation of the stomach from the large amounts of ether and air that were taken in. It is unfortunate that we are compelled to accept the services of untrained anesthetists. One of the most important duties the physician is called on to perform is the administration of the anesthetic in an operative case. We are going to get into trouble before long if we delegate this to a nurse. The laws of New York state prescribe that no one but a regular medical graduate may give an anesthetic.

DR. FRANCIS REDER, St. Louis: I think that dilatation of the stomach in these cases is due in many instances to the toxic elements of the anesthetic that has been administered during a long period. There are other toxic elements which will bring about the same condition.

DR. SYLVESTER J. GOODMAN, Columbus, reported a case in which the skull of the fetus had been crushed by the attending physician some hours before he saw the woman. The uterus was full of small fibroids. He advised hysterectomy, which was refused on the ground that the child was dead. This woman was again pregnant and he expected to do a second cesarean section the following month.

DR. WILLIAM H. HUMISTON, Cleveland: Cesarean section in an uncontaminated case is so far safer and surer in its results than the high forceps operation, that I believe the time is coming when the high forceps operation will not be resorted to by the general practitioner, but only by the thoroughly trained man in obstetrics.

DR. WILLIAM S. BAINBRIDGE, New York: A woman was brought to me from Bridgeport, Conn., about four years ago, with a history of having had six pregnancies, with attempts at delivery each time, most of them instrumental, with death of the child in each case. She had a justo minor pelvis and came to me for repair. The entire pelvic floor was torn away and the bladder opened. There was a vesicovaginal fistula as well as a rectovaginal fistula. I repaired these injuries, and told her she must not become pregnant again, although she was very desirous of having a living child. She came back to me a year following or a little later pregnant. I told her we should have to do a cesarean section, explained to her what was to be done, and two years ago a child was delivered by cesarean section.

DR. A. S. HOTALING, Syracuse, N. Y.: Two years ago I did a cesarean section for eclampsia on a girl aged 17. She was seven and a half months pregnant, with undilated, unobstructed cervix. About a month ago she came into the hospital as a private patient, having been brought there by her physician, who thought she was in labor. I saw her at 9 o'clock in the morning. She died shortly after 1 o'clock from hemorrhage. Autopsy the next morning disclosed rupture of the uterus. The organs were all transposed. The rupture was directly through the old scar.

DR. HUGO O. PANZER, Indianapolis: Bearing on the multiple etiology of gastric dilatation, I wish to report a case that recently came under my observation in support of the supposition of Dr. Davis that in his case acute pressure applied to the stomach may have been a factor in producing gastric dilatation. The patient put on a snugly fitting corset to attend an automobile race, and was brought away from there in convulsions. Examination disclosed that she had gastric dilatation which was brought on by constricting her abdomen too tightly by means of this corset.

Mechanism and Treatment of Placenta Prævia

DR. HENRY SCHWARZ, St. Louis: 1. No form of placenta prævia, as such, ever offers a justifiable indication for cesarean section. 2. Version after Braxton-Hicks in the presence of a viable child deliberately sacrifices the life of that child, and

has no place in modern obstetrics. 3. The cervical and vaginal tampon and the interuterine use of rubber bags are safe and efficient means for controlling hemorrhage and for securing sufficient dilatation for delivery through the natural passages.

DISCUSSION

DR. E. GUSTAVE ZINKE, Cincinnati: It is just as wrong to say that cesarean section is never indicated in placenta prævia as it would be to say that the only operation for placenta prævia is cesarean section. When I read a paper on placenta prævia eleven years ago advocating cesarean section for that condition, I did not find a single supporter. I was not the first to recommend it for placenta prævia. That credit belongs to Lawson Tait. I performed my first cesarean section for placenta prævia about two months ago. A case of placenta prævia centralis in a normal uterus, in which the placenta has been formed in the normal way, in which the placental tissues do not penetrate the uterine musculature and in which the thickness of the uterine wall is uniform throughout, even at the placental site, will admit of dilatation, in many instances, without serious hemorrhages from the hands of a skilful obstetrician. The situation is entirely different when we have a diseased musculature and a normal implantation of the placenta into the muscle of the uterus. Then there is not the separation that there is in the other case, and hemorrhage is uncontrollable in spite of the best means of handling the case, whether the position be vertex, breech, transverse or what not. Then in cases of rigid os, when there are hyperplasia and possibly incipient malignancy which is not recognized at the time, dilatation does not take place until the patient continues to bleed, and the moment the obstetrician introduces his hand for the purpose of dilatation, the patient is likely to be brought to the verge of death before the child comes out of the uterus. These are the cases for which I have recommended cesarean section.

DR. MILES F. PORTER, Fort Wayne, Ind.: If a woman is in good health and is known to be the possessor of a viable child at term, with a placenta prævia centralis, she can be given a better chance for her own life and that of her child by a cesarean section at the hands of a good man than she can by any so-called obstetric procedure at the hands of the best obstetrician ever created.

DR. JOHN NORVAL BELL, Detroit: I would take exception to the remark made by Dr. Schwarz that cesarean section is not indicated in any form of placenta prævia. My remarks were directed entirely to placenta prævia centralis.

DR. MAGNUS A. TATE, Cincinnati: In a case of malignancy of a fibroid tumor complicating pregnancy, I would make a cesarean section for the malignant condition or for the fibroid tumor, and not for a case simply of placenta prævia centralis. One of the crying needs at present is for more trained obstetricians and fewer skilled surgeons.

DR. CHANNING W. BARRETT, Chicago: I believe cesarean section for placenta prævia is much overdone in the hands of general surgically trained men. I believe, further, that if more of these cases fell into the hands of trained obstetricians, more would be treated through the natural route and fewer cesarean sections would be done.

DR. CHARLES L. BONIFIELD, Cincinnati: There is no branch of medicine more neglected in the medical schools of to-day than obstetrics, and if there were more trained obstetricians cesarean section would not be performed as frequently as it is. There are certain cases, however, in which a skilled surgeon is better than a skilled obstetrician.

Rapid Dilatation and Accouchement Forcé

DR. HENRY S. LOTT, Winston-Salem, N. C.: Delivery should be made in all cases of puerperal convulsions, if the patient is at all near full term, on the appearance of even initial labor pains. With strict asepsis and forcible, rapid dilatation, preferably manual, the application of forceps and delivery by the natural outlet are safest and will give the best results. Delivery should be effected under ether, and with care and deliberation. In the two cases of tear of the sphincter which I report in my paper, I firmly believe that greater deliberation in delivery would have lessened the extent of the injury.

Puerperal Thrombophlebitis

DR. PALMER FINDLEY, Omaha: Ligation of the pelvic veins in this condition is correct in theory, but is yet in the experimental stage. After reporting four cases, I submit the following propositions for consideration: 1. Trendelenburg's operation is correct in theory, but is yet in the experimental stage. 2. It is contrary to my practice and to modern teaching to open the abdomen in the course of puerperal infection unless for drainage in general peritonitis, and I therefore view Trendelenburg's suggestion with misgivings. 3. We are as yet unable to demonstrate clinically the extent to which the infection has traveled, and hence it follows that an exploratory incision must be the final resort in determining the extent of the infection, though even this may fail to give the desired information. 4. The pelvic veins, including the iliaes, may not be thrombosed, yet the infection may attack the veins higher in the abdomen and beyond control, and even beyond inspection through an exploratory incision. Furthermore, bacterial emboli may lodge in the lungs and elsewhere without the formation of thrombosed veins. 5. The thrombosed veins may be secured and the infection later travel by other avenues and lead to a fatal issue. 6. It is not always possible to demonstrate the presence of infected emboli which, when found, are viewed as contra-indications to operative interference. 7. I believe that the Trendelenburg operation will find a limited field of usefulness in obstetric surgery, but that the procedure is worthy of an extended trial.

DR. K. ISADORE SANES, Pittsburgh, Pa., read a paper in which he reviewed the literature on thrombophlebitis.

DISCUSSION

DR. R. R. HUGGINS, Pittsburgh, Pa.: I believe that recovery occurs without operation or under palliative treatment in many cases of thrombophlebitis; but my experience shows six cases of the severe form of thrombophlebitis in the last twenty years, with five deaths, with palliative treatment. I resolved two years ago that in my next case of septic thrombophlebitis I would explore the abdomen and see what the matter was. I did this, and the patient recovered. Since that time I have had three other cases, a total of four, with three recoveries. The abdomen should be opened in the midline, which will give a good view of the veins in the pelvis and abdomen. In my experience the operation does these patients no harm. They stand it very well. Even when there is an accompanying lymphangitis, I do not see any objection to operating, especially when the condition has extended along the ovarian veins under the retroperitoneal space, a position or place in the body which is most dangerous if the condition is allowed to progress. If the veins are tied from within, it is easy to make an extramedian incision, push the peritoneum forward and drain behind the veins, or excise the ovarian veins down deep in the pelvis, and the operator will not only have ligated the source of infection, but will have drained the infected spaces, and the patient is much more likely to recover.

Ectopic Gestation

DR. SAMUEL W. BANDLER, New York: It is difficult to make a positive diagnosis in many cases before the stage of hematocoele, in some cases unless the hematocoele is organized. Vaginal incision is of value in making the diagnosis, and "blue shimmer" in the vesico-uterine fold is important.

The specimen shows an exceedingly small ovum not sufficiently large to fill the normally narrow lumen of the isthmian portion of the tube. At this point the tube shows some anomalous features. A muscular spur formation is present, causing a diverticulum to form with its blind end buried in the mesosalpinx, and on the mesial aspect of the point of nidation. The ovum rests on and is imbedded in a muscular eminence to the distal side of the muscular spur, and is nowhere in connection with the diverticulum on the proximal side. It projects into the lumen of the tube but is covered by tubal epithelium. This covering is complete in the half nearest the uterus, but only partially in the half nearest the fimbria, where it may be assumed to suggest a bevinial intra-capsular rupture, and a very early intratubal rupture.

The embryo as such is not present. It is represented by several large masses and streaks of trophoderm which lie near the trophoblast, and contains fresh blood in contrast to the rest of the coagulum. There is as yet no true chorion formation. Leukocytes are present underneath the base of the ovum between the loose muscle fibers, and nowhere else in the serosa, musculature or mucosa of the tube. In view of the total absence of evidence of salpingitis this leukocyte infiltration can be assumed to indicate a secondary local reaction and not a primary inflammation.

DISCUSSION

DR. J. HENRY CARSTENS, Detroit, reported a case of pregnancy which simulated extra-uterine fetation or pus-tube.

Injuries of the Pelvic Floor Resulting From Labor

DR. FREDERICK BLUME, Pittsburgh, Pa.: The public ought to be informed that injuries of the pelvic floor are unavoidable in the vast majority of cases, and that their repair is the end-act of labor. Careful examination and immediate repair should be the rule in ordinary cases. If the tear extends into the bowel or through the sphincter, the operation may be done on the day following labor, with better light, assistance, etc. It is strange that even at the present time some obstetricians do not deem it necessary to repair the laceration, but leave the restoration of the pelvic floor to Nature.

The Complete Absence of Milk in the Primipara

DR. FRANCIS REIDER, St. Louis: The causes that may bring about in the healthy woman a primitive agalactia in its extreme degree can be found in a very youthful motherhood, when normally a deficient development in the secreting cells may be expected. It can be found in the motherhood of advanced age, in which normal atrophic conditions of the gland have caused extensive cell destruction. A tendency to fatness sometimes completely inhibits the functional activity of the gland. Furthermore, a tendency toward the masculine may seriously affect milk secretion and in rare instances be the cause of agalactia. Physical influences, such as emotions of sudden onset, fright, shock, etc., are prone to bring on by their depressing reflex action on the sympathetic nervous system injurious influences that may inhibit cell activity in the organ. In my paper I report three cases of agalactia in three primiparas. In these the cause must be attributed to psychic influences inasmuch as there is no other discoverable factor to which the condition could be assigned. It cannot be disputed that the nervous system exerts some influence on milk secretion. It remains to be demonstrated whether or not such an influence is direct or indirect. As the method of control for the action of hormones is also through the sympathetic ganglia, the shock which these primiparas suffered during their severe labor must be looked on as a potent factor in causing the agalactia.

Moral and Ethical Aspects of Feticide

DR. E. A. WEISS, Pittsburgh, Pa.: A careful consideration of the moral aspect of feticide brings prominently to our attention several facts. 1. The large number of abortions performed is becoming a serious menace to the health and welfare of our people. 2. Such termination of human life is a most serious matter and every possible safeguard should be taken to restrict it. 3. There seems to be a gradually increasing tendency on the part of the laity as well as the profession to take advantage of the law and teaching which permits and sanctions the induction of abortion. 4. In most medical colleges a student has not positive teaching on the moral aspects of abortion, and he is allowed to work out his own ideas with regard to its ethical aspects. 5. There is a gradual loss of respect for religious teachings which have always condemned the taking of the life of an unborn and unbaptized child as a sin and murder. 6. Many, if not all the members of this Association, are teachers and leaders in obstetrics and gynecology in their respective communities, and the responsibility of this teaching rests with us. I plead for a more humane view and consideration of the rights of the innocent unborn child.

(To be continued)