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COMPARATIVE MERITS OF INCISION AND DILATATION OF THE
MOUTH OF THE WOMB IN CASES OF DYSMENORRHOEA, &c.

[Read before the Boston Society for Medical Improvement, August 27th, 1866.]

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EVERY member of this Society must have often been impressed with the tendency which exists in the profession to be unduly influenced, I might, perhaps, with propriety say *overawed*, by the opinion of those who have attained a commanding position in our ranks. This tendency I consider an exceedingly unfortunate one—it destroys self-reliance, individuality; it prevents the physician from faithfully performing his duty; inasmuch as he yields his dearly bought and invaluable experience to the decided, oracular dicta of others. However much we should value and endeavor to profit by the instructions of our fellow-laborers, we should never be willing to relinquish our own convictions, unless satisfied we are in error; until it is clearly shown that the course we have pursued, and are still pursuing, is erroneous. These thoughts have been suggested by the following circumstance. Since our last meeting, a gentleman called upon me with his wife, who desired my professional advice. She had been an invalid for some length of time, complaining more particularly of dysmenorrhœa. I carefully examined her condition, and found she had a retroflexion of the uterus, the body of the organ being so completely bent upon the commencement of the neck as to cause almost a complete obstruction of the cervical canal—admitting the passage only of a very small metallic dilator. I told the husband what derangement existed, and the course which should be pursued to remove it; that I should advise the introduction of sponge-tents to produce dilatation, and, when this should be accomplished, the wearing of a stem-pessary until the distortion should be permanently overcome. He at once told me that Dr. —, who had seen his wife, stated that the plan I now suggested would *formerly* have been pursued—that it was not now, however, practised by the profession, but that *incision of the neck* was the only approved method.

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As the physician referred to has been a practitioner for quite a number of years, and consequently must have seen a greater or less number of cases similar to the one now spoken of, he evidently in this instance tacitly yielded his opinion to the *weight of authority*.

I think he must have read an article on "Dysmenorrhœa, Metrorrhagia, Ovaritis and Sterility, depending upon a peculiar formation of the Cervix Uteri, and the Treatment by Dilatation or Division," which was published in the last volume of the *Transactions of the Obstetrical Society of London*, by Robert Barnes, M.D., President of the Society, and also that he must have coincided with the remark of Dr. Marion Sims, made at the meeting at which that communication was presented, "that that Society must be taken as the representative of professional opinion on any subject falling within its domain." Now, however willing we may be to admit the value of the *Transactions* referred to, we are unwilling to allow the infallibility of any, even of the *most distinguished* of that Society. And even at the meeting referred to, it was evident that no little diversity of opinion existed between Drs. Barnes, Baker Brown, Greenhalgh, Routh, Savage, Hewit, Wyner Williams and Sims, as to the location of the obstruction in dysmenorrhœa, and the local treatment, whether by dilatation or division.

Thus, Dr. Barnes considers the "seat of the obstruction," to use his own words, "almost invariably at the *os externum*. The obstruction is due chiefly to the *small, round os itself*; partly to the pointed, elongated form of the lower part of the vaginal portion, and partly to an unusual rigidity of structure of this part, which impedes the expanding action natural to the healthily formed *os uteri*."

Mr. Baker Brown, on the contrary, differed from Dr. Barnes as to the seat of the stricture; he believed it to be in the *cervix itself*, generally accompanied by narrowing, contortions, and reflexion of this canal—the results of inflammation.

Dr. Greenhalgh considered, from a long experience, that in a great majority of cases the stricture exists *at the internal os uteri*.

Dr. Routh coincided with Dr. Greenhalgh.

How utterly absurd to allow our judgment upon *this point* to be swayed by the opinions of either of the gentlemen above quoted, when the experience of every week assures us that the obstruction referred to may, and *does*, exist at any point from the outer to the inner *os uteri*.

But especial reference I would make as to the manner of *overcoming this obstruction*, wherever it may exist.

Drs. Barnes, Baker Brown, Greenhalgh and Sims, strongly advocated the employment of the metrotome or hysterotome; that a free incision be made; and Dr. Greenhalgh urged that the *internal os* should be dilated as well as the external *os*.

In other words, after the profession have for a series of years considered that, in the vast majority of cases, a contracted, *an almost*

impervious os and cervix uteri may be dilated, and in many instances the suffering produced by this impediment removed by the employment of metallic dilators or sponge-tents, we are told by the President of the Society referred to, that "*incision* is now considered not only as justifiable, but as the *only efficient and permanent remedy* for dysmenorrhœa." Mr. Baker Brown, Drs. Greenhalgh, Routh and Sims appear to have coincided with this view of the subject.

And why is this plan so strongly advocated? Dr. Barnes says:—"Hæmorrhage, pyæmia, cellulitis, peritonitis, have undoubtedly followed dilatation; and it is certain that in many cases, however good the dilatation effected by bougies or tents may appear at first, it is *not of long duration*. I suppose there is no dilatation by instruments more powerful than that effected by pregnancy and labor, yet after giving passage to a full-grown child, the peculiar cervix will sometimes completely resume its old vicious form."

Mr. Baker Brown agreed with Dr. Barnes "that *dilatation* was an *inefficient* and only temporary remedy for dysmenorrhœa arising from the stricture of the canal."

Dr. Routh "had seen *cellular abscess* and *death* follow the use of sponge-tents."

We remember having seen, in some New York journal a year or two since, similar remarks to have been made by Dr. Fordyce Barker and others respecting the employment of *sponge-tents*; that they had seen injurious results produced by their employment. It would be presumptuous in the extreme for me to doubt the statements of these gentlemen; I believe they stated the truth; I allow all they utter *may* occur. But is any known remedy *always* reliable? Is any known operation always successful? Is not an invalid sometimes *made the sicker* by the dose administered? the suffering one *made permanently* a sufferer by the surgeon's knife? May not some of the evils thus produced by sponge-tents be unnecessary? May not the time at which they are introduced, the size of the tent, the manner of its introduction, influence the effects produced? Not unfrequently, particularly in hospitals, this operation would be advised by the attending physician, but be performed by a less skilful hand, even by a nurse. Should there be an unusual excitement of the parts, such as frequently exists just preceding or following a menstrual period, it would of course be contra-indicated. The size of the tent is of great importance. We can readily conceive that a large tent, which is capable of being dilated to a great extent, should cause much distress at the moment of introduction, and produce long-continued and serious constitutional derangement. The operation itself may be improperly performed. If, instead of being carefully introduced, and the effects produced being watched, the dilator is carelessly, roughly, unfeelingly forced into the sensitive parts, suffering to a greater or less extent must inevitably be produced. This is self-evident. From a somewhat extensive employment of sponge-tents during the ten past

years for the treatment of dysmenorrhœa and sterility, I have formed conclusions different from those of the gentlemen of whom I have spoken. I have not unfrequently been disappointed in the result hoped for. The local obstruction has almost always been overcome by the long-continued, persevering employment of the dilator; but the opened canal does not always remove the condition thought to depend upon its closure—dysmenorrhœa and sterility still remain. I have, however, never seen the ill effects spoken of from the employment of tents. I cannot recall a single instance where more than a few hours' inconvenience has been produced; and in such cases the expanded sponge, when removed, has proved to have been originally much larger than it was supposed to be—showing that he who employs these tents should be acquainted with their uncompressed dimensions. My experience has taught me, then, that these contractions, however firm they may be, may almost invariably be overcome. The physician need not feel that the part is undilatable because the application of three, or five, or half a dozen tents does not overcome it; in a case occurring in my practice about a year since, *eighteen* sponge tents were introduced at intervals of two and three days before the canal was opened. My perseverance was rewarded by the perfect relief of the patient. I could point, were it necessary, to several cases where, after years of sterility, the sufferer has been relieved and borne children, and in the intervals in their childbearing have suffered no dysmenorrhœa. I have repeatedly seen cases of dysmenorrhœa remain relieved for years, and known no return. In a word, I have relied upon dilatation to relieve these affections, and whatever opinions may be advanced by others, so long as I feel we have a remedy from which we can confidently expect relief, and very rarely observe any injurious effects, I shall feel it my duty to employ it.

That cases do occur where the difficulty *cannot* be removed by dilatation, there can be no question; but "that incision is the only efficient and permanent remedy (in most cases) for dysmenorrhœa," I unhesitatingly deny.

Let us for a moment look at the method proposed. Those who advocate it should of course be satisfied that it has superior claims over the means now employed. I have thought the ill effects produced by *distension* might be occasioned by want of care; but those arising from incision *may* follow the operation of the most skilful surgeon who advises it, when the metrotome cuts through the walls of the *inner os*; and Dr. Barnes states, to employ his own language, "there is no doubt that the surgeon has actually cut through the substance of the uterus, and wounded the plexus of vessels outside; hence severe and dangerous hæmorrhage has ensued, and inflammation of the peri-uterine tissues." And even supposing the operation should be successfully performed, it is acknowledged by Dr. Routh, one of its advocates, "that such an amount of contraction frequently exists as to render it necessary to have a dilating substance worn

for a considerable length of time to prevent its perfect occlusion"; and Dr. Williams observes that "oftentimes no relief is afforded. He had seen a patient whose cervix uteri had been slit up on both sides, forming two large protruding lips, without affording any relief to the sufferer." Where the external os has been almost cartilaginous to the feel, I have overcome the obstruction with the hystero-tome; but I have never attempted to divide the internal os. I cannot, however, recall the instance where it was required.

Fortunately for those who object to *unnecessarily experimenting* upon the os and cervix uteri, there were those at the meeting when Dr. Barnes read his paper, whose opinions coincide with ours upon this subject. Thus, Dr. Savage, Physician to the Samaritan Hospital for Women, who was in the habit of treating the severest cases of the character I have spoken of every week, assures us he never failed to remove the obstruction with the sponge-tent; and Dr. Graily Hewitt observed that where the cervix uteri was not hard and tense, he preferred to employ the tents as dilators. With these opinions Dr. Williams also coincided.

Enough has been said, I trust, to prove that the profession *generally* do not advocate the *indiscriminate incision* of the cervix uteri in cases of dysmenorrhœa; that the physician should yield his scientific opinion only when convinced of its error; that carefully-attested facts are of infinitely more value than the dogmatic teachings of the *highest authority*.

DR. WEBBER'S ESSAY ON CEREBRO-SPINAL MENINGITIS.

[Continued from page 167.]

DR. E. HALE published a work on the spotted fever as it appeared in Gardiner, Me., in the spring of 1814. His account of the symptoms is very full and interesting. He noticed the sudden and violent manner in which it frequently made its attack, and the great variety in the symptoms. "In the earlier part of the epidemic period the disease always commenced with severe pain in some part of the body, which, if it did not begin there, soon extended to the head and back; and in a few cases the pain increased, till in a short time it produced a delirium. Later in the season, however, pain was a less constant symptom." "Besides the varieties of pain which I have mentioned, there was in several cases, during the first day or two, acute pain in the chest, accompanied by a cough and expectoration of thick mucus, often streaked with blood. Early in the season this symptom was pretty common, but afterwards it seldom appeared. The cough and expectoration were considerably common in cases where there was no pain in the thorax." Nausea and vomiting, thirst, chilliness and a weak, rapid pulse are mentioned among the symptoms.

He mentions a second stage, in which vomiting was the principal

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