

# REPORT OF LAST YEAR'S WORK IN THE GYNÆCOLOGICAL WARDS OF THE MATER HOSPITAL, BELFAST.

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LET me say at the outset that I have nothing new to communicate in this paper. My object in submitting this Report to the Academy is for the purpose of eliciting information in the discussion which I hope will follow.

No annual report of the Mater Hospital has been issued to the public for some years. The medical staff of the hospital were, therefore, not periodically called upon to summarise their work during these years. At the end of the last financial year I thought I would like for my own satisfaction to have a list of the operations done in my department during that period. My house physician very kindly tabulated them for me. This Report will deal with the operations recorded in that list and performed between the 1st November, 1902, and 1st November, 1903.

As a number of operations for different diseases will be referred to, my remarks on each class of operations must necessarily be brief. I do not propose to waste your time with any detailed notes of cases.

During the year 107 patients had operations performed on them. Of these, 44 were curetted for metritis and endometritis, 5 for incomplete abortion, and 2 for advanced cancer of the uterus. Four patients had the breast incised for scirrhus, and one for a large cyst. One

had hæmorrhoids removed by clamp and cautery, 4 had operations for rectal fistula and fissure of the anus; 4 had perinæorrhaphy performed for ruptured perineum; 3 had trachelorrhaphy done for laceration of the cervix. In 2 patients I excised the vulva for tubercular ulceration, and in 3 the hymen for ulcerations and vaginismus.

I operated on one vesico-vaginal fistula and on two recto-vaginal fistulas. I removed one submucous fibroid by morcellement, and there were five cases of urethral caruncle either excised or cauterised. There were 25 intraperitoneal operations performed during the year, 2 being for papillomatous cysts of the ovaries, 2 for extra-uterine foetations, 1 for adhesions of stomach and bowels, 1 for diseased appendix, 9 for cystic ovaries, 9 for fibroid and fibro-myomatous tumours of the uterus, and one for an intraperitoneal abscess.

There was only one death in the wards during the year.

Patients who require curetting are always admitted into the hospital and are submitted to a course of antiseptic douching for two or three days prior to the operation. If the leucorrhœal discharge is profuse and purulent the preparatory treatment is more prolonged. If there has been a recent gonorrhœa the operation is deferred until the acute stage has been passed. I think there is a special danger of septic infection being caused by curetting during the acute stage of gonorrhœal vaginitis and endometritis.

Up till recently creolin has been used in all vaginal operations as an antiseptic. Lately I have taken to biniodide of mercury—1-2,000—as a more reliable douche.

Dilatation is usually done up to No. 11 Hegar, but often, if the difficulty of dilating is very great, I am content with No. 9 Hegar, as it permits equally well of thorough curettage.

In cases of incomplete abortion, where large pieces of placental tissue have to be scraped away, a dilatation to 12 or 13 Hegar is always made, as it enables of a free manipulation of the flush curette and the easy discharge of all *débris*. After curetting, except in incomplete abortion cases, I apply strong carbolic acid in crystals to the endometrium. The intra-uterine douche is used both before and after this application.

I have ceased packing the uterus after any of these operations. I have always found it locks up the secretions inside the uterus, and I doubt if it assists in diminishing the size of that organ by producing contractions to expel the foreign body. For the purpose of toning up and contracting the uterus I always put the patient, after curettement, on a course of ergot and strychnine, with or without quinine, for three weeks or a month.

To assist the operation and effect a cure I regard rest for ten days in bed after curetting as a most essential part of the treatment. For the relief of the ovarian tenderness and the pelvic pains which these patients usually suffer from, more is required than simple curetting. This operation should be followed by treatment directed to the relief of these symptoms. I have had very satisfactory results in such conditions by the use of the hot dry-air apparatus introduced by Reitter, of Vienna. By this apparatus temperatures of 120° to 150° Centigrade can be obtained, and when made to act upon the lower abdomen its therapeutic advantages are most marked. It not only relieves those vague pains which we are too readily inclined to attribute to hysteria, but it induces absorption of cellular exudates in the broad ligaments and pelvis in a very satisfactory way. It is, however, not suitable where there is active inflammatory mischief going on.

The disappointments, which I expect everyone meets with in the failure of curettage to cure the disease for which it is performed, are due, I think, to too much reliance being placed on the operation as the one remedy necessary to effect a cure. In many cases curetting should be regarded as the first step in the treatment, to be followed by other measures directed to the particular constitution of the patient and the presence of other local pathological conditions.

It is only in the arrest of hæmorrhage depending upon the retention of a piece of placental tissue left behind after an abortion that we see the immediate good and permanent effects of curetting. I think, however, it is bad practice to use the curette, or even the finger, to clear out the uterus at once in every case of inevitable abortion which we are called upon to attend. I have had the advantage of a fairly large obstetrical practice for close on thirty years, and I have never had a death, or, I might say, even morbidity, as a result of abortion. I leave the patient alone until the amount of hæmorrhage requires attention. Then antiseptic tamponage for twenty-four hours, with the administration of a few full doses of ergot, will bring the ovum in its entirety into the vagina, or so low down in the uterus that it can be removed by the finger without the slightest trouble.

The value of curettement in cancer of the uterus too advanced for radical operation is very great. Only two such cases came under treatment during the year. It is impossible in a general hospital to do justice to these unfortunate cases. But if the diseased tissue were scraped away frequently, and then touched over with some caustic, all foul-smelling discharges could be prevented, and the patient would enjoy comparative comfort. Since about fifteen years ago, when I had an opportunity of treating a

private patient in this way, I have been convinced of its usefulness. I saw her every second day or so, and as soon as any discharge occurred, or any diseased tissue appeared, I scraped it with a blunt curette and applied to the surface acid-nitrate of mercury. This gave her very little pain, and it kept her dry and comfortable to the end.

In all tumours of the breast in which I have any doubt as to their malignancy I advise excision. Five mammary glands were removed during the year. Four were affected with scirrhus, and one had a cyst so large as to require complete removal of the breast. The axillary glands were affected in all the scirrhus cases, and were cleared out. In doing this I make a complete dissection of the axilla, removing all the glands and cellular tissue. Glands up, under, and above the clavicle are removed if found enlarged. In one of the cases I removed the thoracic portion of the pectoral muscle, because the growth was firmly adherent to it.

Perinæorrhaphy was performed in four cases for extensive tears and commencing prolapse with satisfactory results. The method recommended by Tait was adopted in all the cases. In incomplete lacerations, if the incisions at the sides are made deep and the parts accurately brought together from the bottom of the wound upwards, no method gives better results.

Two cases of extensive ulceration of the vulva were admitted which had resisted a great variety of local and constitutional treatment outside. In one case the clitoris, the anterior commissure, the labia minora, and the adjacent surfaces of the labia majora and mons, and far up into the vagina, were affected by tubercular ulceration of nearly two years' duration. I excised the entire area well clear of all disease and brought the edges together above on the mons veneris and down the anterior com-

misure to the urethra. The labia majora were sutured to the mucous membrane of the vagina. Though there had been extensive removal of structures and apparent mutilation, when the sutures were completed the parts again assumed a fairly normal appearance, and united admirably.

The second case was less extensive, but was treated in a similar way, and did well.

The case of vesico-vaginal fistula which was operated on had an opening of three-quarters of an inch in diameter. Closure was effected by flap-splitting and suturing with silk in the long direction of the vagina. The catheter was passed every five hours for six days. No leakage occurred until the sutures were removed on the tenth day, when some came away from a small pin-hole opening which required two subsequent operations to close. The catheter was tied in in the last two operations for a week.

Of the two recto-vaginal fistulas which were operated on the first was :—

A patient, aged twenty-three, a primipara, who had been confined ten months previously. The fistulous opening was about one inch in diameter, and was low down near the sphincter. There was only a thin band of tissue in the recto-vaginal septum at the perineum. I retained this band, but forcibly stretched it and the sphincter, taking care not to tear through the band.

I then did a Tait's perinæorrhaphy, separating the flaps, including the narrow band, well up into the vagina, and to at least half an inch above the highest point of the fistula. The edges of the fistula were then united by buried catgut sutures on the vaginal side, avoiding entry into the rectum. Long silkworm gut sutures were then passed from one side to the other, buried throughout their entire extent. Before tying them a further layer of catgut buried sutures, superimposed on the first, were passed to draw together the deep parts of the wound. The silkworm gut sutures were next tied, and then the fistulous opening in the vaginal mucous membrane was brought together by another set of fine silk sutures. The bowels were moved by a purgative on the

second day after the operation, and kept open by daily purgatives until the sutures were removed, on the twelfth day, when complete closure had taken place.

The second patient was a large, flabby, stout woman, sixty-two years of age, with a large irregular fistula, extending high up in the vagina, about two and a half inches by one inch. It had been in existence for twenty years, and its margins were puckered and distorted by firm and dense cicatrices. With the exception of a band about the thickness of the little finger at the perineum the recto-vaginal septum was open from the sphincter to Douglas' space. This band was so hard that dilatation could not be satisfactorily performed.

The steps of the operation were similar to the previous one, and closure was effected in the same way. After the operation the bowels could not be got to act until large repeated doses of different purgatives had been administered. Diarrhœa then set in, and the motions came away involuntarily, soiling the dressings. On making a digital examination of the rectum on the seventh day it was found to be filled by an immense scyballous mass. The tension of the sphincter had occasioned this block, and there was a deep cloaca above the vaginal band referred to, in which the fæcal mass lay. This mass was broken down with the finger, and removed with considerable difficulty, and the bowels washed out with an enema. Stitch abscesses formed and perfect closure did not take place. A good perineum, however, had been established by the operation, but a fistulous opening existed in the centre of it, and a small fistula, about half an inch in diameter, remained inside the vagina.

A second operation was performed about one month after the first to close these openings, with complete success. The patient was obliged to leave for home seventeen days after the second operation. When she left there was only a small opening externally in the new perineum communicating with the bowel, which has since closed. The good result obtained by the second operation was due to more perfect dilatation of the sphincter at the operation, and more careful attention to the bowels after it.

Twenty-five laparotomies were performed during the year, with one death, which was the only death in the gynæcological department during the year.

This patient had been operated upon for an ovarian cyst in Sir Patrick Dun's Hospital two years previously. She presented a marked cachetic appearance, was much wasted, and suffered a good deal of pain. Her entire abdomen was filled with a resistant swelling, bulging down into Douglas' space and both sides of the uterus. The patient was in a very weak condition, but as she desired an operation I decided to make an exploratory one. I found a papillomatous cyst, as I had anticipated, with extensive proliferations and adhesions. The tumour was adherent to the spleen, intestines, bladder, uterus, and abdominal wall. Some of the adhesions near at hand separated very easily, and I was tempted to go on until hæmorrhage occurred so severe as to necessitate the complete removal of the tumour. All hæmorrhage was checked before closing the abdomen, but the patient was collapsed after the operation, and died seven hours afterwards.

I operated on another papillomatous cyst during the year, which was also diagnosed before operation:—As in the previous case, the patient was much wasted and extremely weak. Her greatest trouble was an inability to retain her urine. I made an exploratory operation and found proliferations so extensive that I contented myself with separating the adhesions binding down the bladder. She recovered from the operation without the least inconvenience, and she got immediate relief from the bladder trouble, and left hospital a month afterwards.

I regard it as useless to remove papillomatous cysts when sprouting has taken place throughout the abdomen. The entire disease cannot be removed, and the patient's condition is very little improved, and I doubt if life is anything prolonged by a partial removal.

Ovariectomy was performed in eight cases with good results.

One had a septic peritonitis for two months before the operation, and was very much wasted. Her temperature ranged between 100° in the mornings and 103° in the evenings. She had a pulse averaging about 120. I waited for nearly six weeks in the hope



that the fever would subside, because I was afraid, if operated on, she would either die on the table or get general septicæmia afterwards. As no improvement took place, and as death seemed quickly approaching, I gave her the chance of operation. The tumour, which filled the abdomen up to the costals, was a multilocular ovarian cyst, and one of the cavities was filled with pus. There were general adhesions all over, which broke down very easily. The usual signs of peritonitis were present, but there was no pus in the abdomen. I flushed her out well with warm saline solution, and left a considerable quantity inside the abdomen. Her temperature was normal the evening of the operation, and fluctuated very little afterwards, and she made a good recovery.

There were two cases of ovarian cysts with twisted pedicles. Both had histories of inflammation. One was diagnosed as appendicitis, and was sent to hospital for appendicectomy. The tumour was not a large one, and, owing to the tympanitic distention of the abdomen, the mistake was perfectly excusable, but on careful examination the nature of the case was evident. In the other twisted pedicle case the cyst was completely encircled with omentum, and the vessels of the pedicle thrombosed. These two cases recovered without a bad symptom.

One patient, a small woman, had an enormous ovarian tumour. It hung down over her pubes to her knees. It contained twenty pints of fluid. It was adherent to the front wall of the abdomen over its entire extent.

There were two cases of dermoid cysts and one of parovarian cyst. The remaining case was a simple unilocular cyst, deserving of no comment.

Nine retro-peritoneal hysterectomies for fibroids and fibro-myomatous tumours were performed during the year. Some were large tumours, filling the abdomen; others were small bleeding myomas. Some were multiple, and had projections which pressed on the bladder in front and

on the rectum behind. The largest was in a patient who had passed the menopause, and who had had the tumour for ten years. After the change of life it began to enlarge and incommode her in different ways. This activity in the growth of a fibroid after the menopause is the reverse of what one has been taught to expect, but I have seen it occur in two or three cases.

I had no deaths among my hysterectomies. The majority of them recovered without having any elevation of temperature to speak of.

I do not now put any ligatures in the stump of the uterus except there is bleeding. If there is no bleeding there is no necessity for them, and I look upon every additional ligature which one has to use inside the abdomen as an increased danger to the patient. The want of certainty which one always has about the sterility of even the most carefully-prepared catgut makes one chary about using it except when absolutely necessary. I make it a rule in all patients for abdominal section, and more especially for abdominal hysterectomy, to give them thorough antiseptic douching for at least a week before the operation. This, I think, sterilises the canal of the cervix, and so prevents the danger of septic trouble afterwards about the stump. I use silk ligatures for all the vessels, and catgut for suturing the peritoneum over the stump. The catgut is prepared by Bergman's method. In all abdominal operations I believe in free purgation before the operation and light diet for a few days. The bowels give less trouble if empty at the operation, and there is less liability to tympany after. I put hot normal saline solution into the abdomen in every case. I suture the abdominal wound in three layers—peritoneal, muscular, and cutaneous—using catgut for the buried layers. I believe I have had firmer union since I have

commenced this method. In all my cases I give practically nothing by the mouth for the first forty-eight hours after the operation. A teaspoonful now and again of toast water is all they get. Nutrient enemata of peptonised milk and egg and of Brand's essence, or other preparation, are given every six hours for three days, and then eased off. The bowels are moved by a saline aperient on the third day.

The two extra-uterine foetation cases were diagnosed and operated on before rupture. One was almost entirely ovarian. The sac was between the fimbriated extremity of the Fallopian tube and the ovary—a large cavity in the latter being filled with placental tissue.

I saw this patient in the extern soon after pregnancy had taken place. She came complaining of pain in the left iliac region, and of an uncomfortable, uneasy feeling which made her apprehensive of something serious being wrong with her. I found the left ovary somewhat enlarged and tender, and applied some ichthyol tampons. She came every week, and the ovary seemed steadily to enlarge. She missed her period, and then about the sixth week she began to have hæmorrhage. I then brought her into hospital and operated on her.

An interesting feature in the second case was the presence of a dermoid cyst on the opposite ovary of the size of the foetal head, which I removed at the same time.

It was filled with teeth and hair, and lay deep down on the left side of the uterus, surrounded by a mass of adhesions.

The diagnosis of an extra-uterine foetation is, in my opinion, a fairly easy matter. The difficulty is to tell when it has ceased to grow and to be of danger to the patient. Extra-uterine foetation must, I think, be of comparatively frequent occurrence, and the majority of

the patients recover without any very alarming symptoms. They grow up to the sixth or seventh week, when a hæmorrhage occurs within the sac, or a tubal abortion takes place without much hæmorrhage, and they cease to give further trouble.

A patient who misses a period, and then gets attacks of irregular hæmorrhages, accompanied by the discharge of shreds of tissue, should be at once suspected of having an ectopic pregnancy. If at the same time an examination discovers a swelling at one or other side of the uterus of a size corresponding to the period of suspected pregnancy, which bimanually is found to move more or less independently of the uterus, the suspicion is strengthened.

Further, if from the time of the suspected pregnancy there has been a painful and an uncomfortable feeling in that side of the pelvis, which has been unaccompanied by fever or other indications of inflammation, the diagnosis of extra-uterine foætation is fairly clear.

Should one have an opportunity of watching the patient for a couple of weeks, and if the tumour is found to grow perceptibly from week to week, there can be no doubt about the diagnosis. The condition of the breasts and discolouration of the vagina may also furnish a further corroboration.

Unless active symptoms have been absent for a considerable time and the tumour shows signs of becoming smaller in size, I advise immediate operation. No one can tell when an alarming hæmorrhage may occur, which may, perhaps, carry the patient off in a few hours. The tubal case referred to in this paper was on the very point of rupturing when operated on.

The patient with the intra-peritoneal abscess which I operated on had been in hospital for two months. She was very much wasted, and had hectic symptoms. There was

a large swelling on the left side of the uterus, rising up half way to the level of the umbilicus on that side. No fluctuation could be discovered per vaginam or by abdominal palpation. On opening the abdomen and separating a mass of adhesions between coils of intestine, I came down upon an abscess at the side of the uterus, dipping down pretty deeply into the pelvis. It contained about 4 oz. of pus. The cavity was thoroughly cleaned out and drained through the abdominal wound. It dried up and did well, but signs of tubercular disease appeared at the apex of the left lung, and the fever continued. She was discharged from hospital six weeks after the operation.

The stomach case operated on was a weak, thin woman, fifty-five years of age. For about twenty years she had suffered from gastric pain and dyspeptic symptoms. Two years ago I performed ovariectomy on her for a large ovarian cyst. At this operation I found adhesions between the transverse colon and the abdominal wall. The upper cavity of the abdomen was completely walled off by these adhesions. It was impossible to separate them through the ovariectomy wound, and the patient was not in a condition to bear a more severe and prolonged operation. The removal of the ovarian cyst, as was to be expected, gave no relief to her gastric troubles. On the contrary, she became thinner and weaker. I brought her into hospital again in July last and operated on her for the purpose of separating these adhesions. They were found to be most dense and extensive. One thick fibrous band extended from the left lobe of the liver to the lesser curvature of the stomach. It was an inch broad, and about one-eighth of an inch thick. The liver about where it was attached was quite black. I cut through the band with a scissors, and it separated widely without the least hæmorrhage. The adhesions between the stomach and transverse colon and the abdominal wall were broken down and divided with great difficulty. Some between the pylorus and liver were too intimate and dense, and had to be left, as the patient had twice ceased to breathe for a time during my attempts at separation. She recovered from the

operation very satisfactorily, and, though not relieved of all her symptoms, she now enjoys better health than she has had for years.

I cannot conclude this brief record of my work without expressing my indebtedness and thanks to my colleague, Dr. Moore, for his able assistance at almost all my abdominal operations, and I also thank you, Mr. President and gentlemen, for the opportunity you have given me of reading my paper before this meeting.