A Short Summary

OF THE

DEVELOPMENT OF THE TREATMENT OF UTERINE FIBROMYOMATA WITHIN THE LAST TWENTY-FIVE YEARS,

WITH A RECORD OF OVER ONE HUNDRED CONSECUTIVE
SUCCESSFUL CASES OF SUPRAVAGINAL HYSTERECTOMY.

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THE development of and success in the treatment of uterine fibromyomata during the last twenty-five years may be considered the greatest advance of gynaecology, and takes its place, in the very van of surgery, or any of the marvellous strides which have been made in medical science. Not so much is this due only to the actual success, but chiefly to the benefits that have accrued to the welfare of enormous numbers of suffering women; for uterine fibroids may be considered one of the commonest causes of prolonged suffering and invalidism to which they are heir.

In 1884 Lawson Tait, to whom we owe so much in the development of gynaecological surgery, wrote¹:

I have now come to speak of hysterectomy, concerning which I may say at once is an operation which I detest. Its mortality is fearful. My own mortality has been 35 per cent. Every patient, or at least nearly every one, who recovers does so, as it were, by the skin of her teeth. The amount of worry which is given me by every case even when successful is such as to be almost beyond the recompense of any fee, and the disappointment inflicted by every death is indescribable.

The mortality at the present time in efficient hands is less than 5 per cent. Comparison and comment is therefore superfluous. The treatment then and now must necessarily be viewed from widely different aspects, and in this connexion the views of Thorburn, one of the most able practical gynaecologists, are interesting and instructive. Writing in 1885 Thorburn in his textbook summarizes as follows:

Given 100 fibroids, 50 at least require scarcely any treatment medical or surgical. They will have no troublesome symptoms, and many of them will be discovered by accident alone, or will not be discovered at all. In the remaining 50, symptoms will lead to diagnosis, and demand treatment of some kind. I think it is not too much to say that of these the great majority may be rendered perfectly endurable and compatible with the enjoyment of life by medical means, including appliances for lifting up the mass and occasional minor surgical proceedings such as scarification, until the menopause brings still further relief or complete cure.

Some 10 per cent. of the 50 may require the aid of the operating surgeon. In certainly not more than one of them is he driven perforce to the repulsive proceeding of vaginal evulsion. In the remaining nine, removal of the ovaries cures the predominant symptoms and ensures absorption of the mass in all but a mere fraction.

These fractions spread over the community amount to a considerable number of cases, and so far we may say that when there is any kind of pedicle to be got for such tumours along with the containing uterus the whole mass may be removed with a mortality of some 40 or 50 per cent.

How different from the expression of opinion of many writers of the present day, according to whom the mere presence of a fibroid nodule is sufficient indication for hysterectomy!

It is questionable from their standpoint whether women with fibroids are happier as a class now than then; 50 per cent. then with fibroids suffered nothing and were allowed to lead an unmolested life, now they are in jeopardy of having the abdomen opened and being unnecessarily mutilated. Fortunately, however, the great bulk of gynaecologists steer the middle course, and affirm that the presence of a fibroid *per se* is no indication for operative procedure, and it is only when actual symptoms develop that treatment is to be considered. With this I am in entire accord.

At the present time the treatment of uterine fibromyomata may for all intents and purposes be divided into electrical and surgical. Medicinal means, with very few exceptions (as, for instance, when slight menorrhagia may

be tided over till the menopause by ergot) may be said to be obsolete.

ELECTRICAL TREATMENT.

Electrical treatment as propounded by Apostoli I cannot but feel has not had accorded to it the deference it deserves. This perhaps is due to the fact that surgical methods have made such progress as entirely to supersede it. From a large practical experience of this method I am convinced that a very considerable proportion of cases are not only temporarily benefited and thus tided over till the menopause, but also are completely cured. When the mortality from hysterectomy and other surgical procedures was over 25 per cent. it was a method of treatment to be strongly recommended, but now that surgical methods are performed with such freedom from danger to life, its uncertainty and tediousness places it in the background. Still there is a proportion of sufferers from fibromyomata who resent operative procedure if any other possible method of treatment is of avail, and it seems to me that there is no reason why they should not have the benefits of a trial of the electrical procedure if they so desire. No more outstanding proof of the value of electrical treatment can be found than the fact that Thomas Keith, who was the most successful hysterectomist of his time, discarded surgery for this method, although in 1883 he had successfully performed twenty-three hysterectomies with but three deaths. Why Apostoli's treatment has failed to be recognized as a standard method of treatment, and is now practically obsolete, is difficult to determine. Perhaps it is due to its uncertainty, and to the haphazard manner it has been recommended and used as a universal panacea, which seems to be the fate of all advances in medical electricity. But there is no doubt in my mind that it is denounced unfairly as dangerous and useless by many who have given it an insufficient trial, if any at all; while others seem to have a completely mistaken notion of its application.

One is surprised, for instance, to read in Hirst's textbook² a description by one who was a member of a Committee of three appointed to investigate the treatment that a current of the strength of 40 milliampères is enough. No wonder the results were negative; and when that is taken in association with the elaborate method of application, little wonder is to be expressed with the fact that the Committee discarded it.

A current of less than 80 milliampères cannot be expected to have effect on a fibroid growth, if it be considered from a physiological aspect, and anything between that and 120 milliampères may be given with the utmost safety. To "unreservedly condemn" electro-negative puncture, as the same author does, is also entirely opposed to my experience; but perhaps it has also been used in a similar unsatisfactory manner. I again repeat that Apostoli's treatment of fibroids is one of great value, and feel obliged to do so from the benefits I have achieved by its adoption. Even now, when surgical methods have attained the extraordinary success they can boast of, it offers to those whose timidity refuses to allow them to undergo the ordeal of the knife an alternative worthy of trial, which must be respected in a free country such as ours. It has also been denounced as not only dangerous, but militating against safe subsequent operation. This, again, I can only infer is the dictum of those who have either not used it at all or have done so in an imperfect manner.

Out of more than 150 cases in which I have followed this method, both by electro-negative puncture and intrauterine positive treatment, I have never seen an untoward result, and in many of these in which I have subsequently had to operate no complications due to the previous electricity were observable.

SURGICAL TREATMENT.

The surgical treatment of uterine fibromyomata may be divided into:

1. Removal of the uterine appendages;
2. Removal of the tumour; and
3. Removal of the uterus and tumour.

Removal of the appendages as recommended by Lawson Tait, like electricity, has had its day, and formed a most valuable method of treatment before the more radical operative measures were perfected. It may simply be mentioned as a milestone on the road of surgical advance,

as its uncertainty of cure, inapplicability in many cases, and impossibility of performance in others, render it rarely worthy of adoption.

Removal of the tumour or tumours with or without the uterus now holds the field as practically the only surgical procedure. This may be performed according to the bent of the operator either vaginally or abdominally. The removal of the tumour alone, when pedunculated, must naturally be the operator's selection, but the removal of sessile fibroids by enucleation is still a much controverted question. From its conservative aspect it has indeed to be favourably considered when the growths are small and comparatively easily reached through the dilated or split cervix. Statistics show the mortality of about 5 per cent. in 1,781 cases collected from various well-known operators.

By the abdominal route, myomectomy is much more dangerous, and shows a mortality of nearly 10 per cent. in 807 cases. Further, it must be remembered how uncertain one must be that no other nodules are left in the uterine wall after the operation is completed. When the mortality and other facts of myomectomy are considered in comparison with the statistics of hysterectomy, it cannot but be apparent that there is much cause for favouring the latter procedure. Indeed, the development of hysterectomy may be said to have revolutionized our treatment of fibromyomata within the last twenty-five years.

Before 1883 there were reports from the various European countries and America of 573 cases collected by Bigelow.³ Of these, 311 recovered and 241 died, so far as could be followed.

As in the development of ovariectomy, the stump was at first treated extra-abdominally, and haemorrhage controlled by wire ligature (*serre-noeud*, Pean), elastic ligature (Hegar), or clamps (Thomas Keith). Schroeder, however, treated the stump intra-abdominally and subperitoneally in the fashion of the present day, with the all-important exception of ligation of the uterine arteries. In his first 25 cases he had 10 deaths. The general mortality from either method was very similar:

Extra-abdominal, 247 cases—mortality 39 per cent.

Intra-abdominal, 84 cases—mortality 39.28 per cent.

Following the development of technique of ovariectomy by intra-abdominal treatment of the stump; in the face of the good results of Bantock and others, secured by the extra-abdominal method, hysterectomy has by the advanced technique of aseptic surgery become an operation of very limited risk. A review of the work of well-known operators of various nationalities within the last five years shows 2,081 cases, with a mortality of less than 5 per cent., and this is rapidly becoming lessened.

My own statistics in this relation show 203 cases by the supravaginal method, with 2 deaths; a consecutive series of 109 cases having been successful. One death occurred on the twelfth day suddenly from embolism. The other took place on the day after the operation on a patient whose blood showed 18 per cent. haemoglobin and 2½ million red cells. Such results cannot be looked upon as other than exceptionally fortunate when one considers the unsatisfactory state of many of the cases operated upon, the result of intense anaemia, and weakened cardiac action. Still, they are sufficiently stimulating in warranting the recommendation of the operation.

Panhysterectomy, or removal of the entire uterus, has been advocated by some operators, but has little specially to recommend it, except in the rare cases in which the cervix is involved by the growth, or some malignant uterine complication is present. It certainly is an efficient bar to subsequent cervical cancer, but this sequel is so seldom met with as hardly to warrant the prolongation of the operation which is necessarily involved, or the increased mortality which is shown by statistics collected from the work of the best-known operators as 8.27 per cent. in 1,668 cases.

CONCLUSIONS.

From what has been said it cannot but be admitted that in the last twenty years our advice to women the victims of fibromyomata must necessarily have materially changed. Instead of commending 90 per cent. to a life of semi-invalidism till the climacteric arrived only probably to relieve their sufferings, we are now able to offer a certain prospect of cure to 95 per cent. at least.

Far be it from me to suggest that every woman the subject of fibromyomata should have to undergo treatment, surgical or otherwise. The excellent summary of Thorburn above quoted is as true to-day as it was when written. Fully half of those having fibroids have no symptoms and should be left alone, for these growths cannot in themselves be considered as a menace to life, or even a barrier to health, happiness, or usefulness.

When, however—as happens in one out of two cases—they cause symptoms from haemorrhage, pain, or pressure, it seems to me reprehensible not strongly to recommend active treatment.

To condemn a woman to a life of inutility and semi-invalidism during the most active years of her existence so that she may possibly spend a comfortable old age surely cannot be considered worthy of our profession when the risk of absolute immediate cure is so slight.

Fibroids are mainly met with in the “well-to-do,” who can afford to rest so many hours daily, spend their “period” times in bed, and go to fashionable spas for change; they thus lend themselves to a temporizing inactivity which is out of the question in the working classes.

Doubtless, in the former class, the patient herself, in the majority of instances, supports the line of inactivity, as, from the slow and insidious manner in which she is reduced to inutility, she is unaware of her weakness and inefficiency, and at the same time is but too ready to coincide with any method of so-called treatment which avoids operation. It is pitiable to think that so many women in early middle life are thus encouraged to exist simply to avoid an operation with so little risk. Still more pitiable is it to know that they are encouraged in this almost suicidal attitude by the advice of those who assert that not only are they unsexed, but are liable to become insane. This canard cannot be too strongly denied as being without even the vestige of proof to substantiate it. Indeed, one might argue from the opposite standpoint; I have performed hysterectomy with complete success, simply on account of the mental condition, upon a chronic inmate of an asylum who after the operation regained her usual mental equilibrium.

In conclusion, I have no hesitation in saying that, now that our methods of treatment are so perfected as to reduce the risk of radical operation to the vanishing point, we are warranted in taking a strong position against long-continued temporizing, and if a woman's health and happiness are impaired by reason of a uterine fibromyoma, to urge its removal.

REFERENCES.

¹ One Thousand Cases of Abdominal Surgery. ² Textbook of Diseases of Women, p. 367. ³ American Journal of Obstetrics, vol. xvi, 1883, p. 1269.

A Lecture

ON

DYSMENORRHOEA.

DELIVERED AT CHARING CROSS HOSPITAL.

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My lecture is on a subject in which a large percentage of one half of the world's population are personally interested, and for the relief of which you will find you will often be consulted.

Now, let me first say that dysmenorrhoea (*δυσ-μην-ῥέω*) is a symptom, and should not be treated as a disease. It is as much a symptom as toothache is, and though you may temporarily mask or obliterate the symptoms by pain-killing drugs, your constant aim should be to try and find out the cause. If you can modify or remove the cause, the pain will also disappear. In cases where the patient is first seen during the actual dysmenorrhoea, you will have to temporarily treat the symptom by sedatives, but in the three weeks following you must try to discover the cause and so to deal with it that the next “period” may be easier.

If the cause be a general or constitutional one, more