THE MODERN TREATMENT OF MYOMATOUS DISEASE OF THE UTERUS.*

By LAWSON TAIT, F.R.C.S., Etc.

It is now nearly thirty years since I first began to engage myself in the practical treatment of diseases of the uterus, and it was in this city and in connection with the institution in which we are assembled as its house and dispensary out-door surgeon. From Edinburgh, where I was in immediate contact with the two Simpsons and less intimately with Matthews Duncan, I had come away with the belief that myomatous disease of the uterus was a mere pathological curiosity, of no importance clinically, and one for which nothing was required to be done, and for which practically nothing was done.

I had, however, to learn conclusions concerning this disease similar to those concerning others—that locality or local influences are influential in determining not only the prevalence of certain diseases, but also in determining their clinical features and personal importance. I had to learn that the severity and course of syphilis are far less severe in Wakefield than as I saw it in Edinburgh, whilst in the Midland Counties and Birmingham it is comparatively a trivial ailment. I had to see in Wakefield four or five cases of cancer of the uterus for one which presented itself in dispensary practice in Edinburgh, and in Birmingham probably this terrible ailment is twelve times more abundant.

My first convictions concerning myoma were that it was not only more frequent, but far more severe in its symptoms than as I saw it in Scotland, and that medicines had no kind of influence on it whatever.

My first surgical experiences were, of course, the removals of myomatous polypi which had been extruded from the uterus, and as these were always completely and at once satisfactory it dawned upon me that some of the cases of enlarged uterus, which evidently were affected by nodules then known as fibroid tumours, might have their symptoms due to masses capable of removal. I followed the example of Marion Sims, who had then first begun his treatment of such cases by dilatation and extraction of them piecemeal. This practice was followed largely by Péan, and subsequently extended by him in the practice of their removal by *morcellement* after abdominal section. The preliminary dilatation by sponge tents had been abandoned by common consent as too horribly dangerous. The tents of laminaria were substituted, and I shall never forget the satisfaction with which I got my first supply. A case was then under my care in which everything seemed favourable, and I inserted with care a very large-sized tent, with the result that my patient died in about forty-eight hours without my ever being able even to start the process of enucleation. A *post-mortem* examination revealed the fact that the overwhelming force of expansion in the tent had split the uterus right across the fundus, and had killed the patient. I put those tents all carefully away, and have never used one since.

The facts now known show that it was our ignorance of the true pathology of the disease and our mistaken nomenclature which led to our blunders. Now that we divide myoma into the hard multinodular and the soft oedematous solitary tumours, we see from the records that the successes of Marion Sims, Péan, and others, must have been with the soft oedematous myomata, and the failures were with the hard multinodular. The great bulk, probably 98 per cent., of the polypi we remove after uterine extrusion belong to the soft oedematous group, and their extrusion is due to the accident of their growth in or very near the cervix, or to their attachment being very limited in area. But as a rule they are not so favourably situated, and therefore they grow to enormous size and grow very rapidly. They may always be attacked by vaginal enucleation until their size stands in the way, tumours of great weight having been removed by Péan's *morcellement*, and there seems little risk in the operation either from hæmorrhage or from subsequent blood poisoning, provided sponge tents have not been employed, and the operation be done with perfect cleanliness, that is,

with perfect aseptic precautions. They are always solitary as I have said, and I have never known one to recur.

In this particular it is clear, therefore, that the surgical pendulum is rushing unduly to the other side. Hysterectomy, that is, the complete removal of the uterus, is being done frequently for cases of this disease, which could have been dealt with quite as easily by vaginal enucleation; and if my own experience is confirmed that these tumours do not recur, I ask that the surgical rule should be adhered to, and that the uterus, healthy and capable of resuming its normal shape, direction, and function on recovery from enucleation, should be left; and that its removal or permanent injury should be undertaken only when the tumours are so large as to render enucleation impossible or more dangerous than removal of the tumours by abdominal section.

Removal of polypoid nodules in cases of multinodular myoma gives benefit of course, but in my own experience this has been only temporary, and whilst it certainly should be employed as a temporary and palliative measure, reckoning should be made with the further progress of the disease.

For multinodular disease the operation of election is removal of the appendages. At the meeting of the British Medical Association at Cardiff in 1885, I published my first series of 108, with a mortality of 1 per cent., a result enough to establish any operation in its primary relations. But I went further than that, and in November, 1890, I published the secondary results of the same series, giving the results of every one of the cases save two, when the patients could not be traced; and that evidence was in the main not my own, but was contributed by practitioners who were interested in the cases and had watched them. No other operation in the history of surgery has ever been sustained by an inquiry like this, and I venture to assert that it is the only way in which an operation can be estimated justly. It would matter very little if an operation had no primary mortality at all if it left the majority of its subjects maimed, halt, or insane at the end of two years. The absence of this kind of inquiry is the cause of so much change of fashion in surgery, to say nothing of medicine. If we took the trouble to ascertain and record our secondary results, our proceedings would be, to say the least of it, more logical and in every way more profitable.

In the cases of soft oedematous myoma the operation of removal of the appendages has been prematurely discredited by one of my own cases, in which I had to do hysterectomy (or rather amputation) of the uterus and tumour some months afterwards (BRITISH MEDICAL JOURNAL, January 8th, 1887), by reason of the continuance of the symptoms and the great increase of the tumour. When I came to examine the mass removed I found my failure to be due to the fact that I had practically failed to remove one of the Fallopian tubes. But this explanation was made to the ears of the deaf—those who still adhere to the belief that the ovaries are the cause of menstruation. If it occurred with some frequency that the tumour increased and the symptoms persevered after complete removal of both ovaries and tubes, it would be time to talk about the inefficiency of the proceedings; but in my own practice, covering now over a thousand cases, I know of the one case only; and if others of my failures had been met with in the practice of other surgeons, I do not think I should have been long allowed to remain in ignorance of the fact.

The third operation, in order of importance and severity employed in the treatment of the myomatous uterus is the supravaginal amputation. I need not here go into the question as to whether this should be completed by an extra- or intraperitoneal treatment of the pedicle. With the former I now get runs of success of thirty, forty, and even as high as fifty-two consecutive cases. But with every kind of intraperitoneal treatment of the pedicle which I have tried, the mortality has been terrible, and I am done with it for ever. It is clearly on this account, although none of its advocates have admitted the fact, that it is now proposed to remove the whole uterus—that is hysterectomy, the name of "panhysterectomy" being as absurd as it is unnecessary.

This has achieved a very considerable amount of success; it is comparatively easy to perform, and it certainly has the enormous advantage of enabling the operator to control the arteries outside the limits of the shrinking uterine tissue, and

* Read before the Yorkshire Branch of the British Medical Association, at Wakefield.

therefore he secures the advantages of the intraperitoneal method without the risk of hæmorrhage when it is attempted to tie uterine tissue.

There are, however, many countervailing disadvantages which have not been considered, I should say have not yet entered the minds of those who are its most enthusiastic supporters. The present paper is specially for the purpose of reviewing a discussion reported in the *BRITISH MEDICAL JOURNAL* as having occurred at the meeting of the British Gynæcological Society on January 14th. A paper was then read by my colleague and former assistant, Mr. J. W. Taylor, on Two Cases of Panhysterectomy after Previous Treatment by the Clamp Operation.

In the discussion the cases were used as arguments for the operation of complete hysterectomy as against the clamp amputation, and it was said that the British Gynæcological Society had declared for the last three or four years that "panhysterectomy was the best operation for myoma." If the Society had said any such thing (and I can find no evidence that it has done so) its opinion has been, to say the least of it, premature. Mr. Bowreman Jessett went further, and is reported as having said that Mr. Taylor's cases showed that by using the clamp "one or several myomata might be left behind, needing such a second operation," as in Mr. Taylor's second case. This allusion to Mr. Taylor's second case is clearly a mistake, seeing that the first tumour was a cystic tumour of the ovary, when for reasons good enough in themselves Mr. Taylor had to revert to the clamp treatment of the pedicle, as he frankly confesses that at that time he knew no better way of treating the condition found. But the uterus was perfectly healthy, and it remained so for some five years, during which time it fulfilled its function of pregnancy. Surely in these days when we have to run the risk of hearing our surgical judgments overhauled by a jury of inquiry, and our surgical operations condemned in the witness box by nurses, it becomes us to repudiate such advice as is given by Mr. Bowreman Jessett. Still more is this conclusion to be advanced when we consider Mr. Taylor's first case, which is probably the one to which Mr. Jessett referred. Mr. Taylor's experience of her was "that she was an unmarried lady" 33 years of age, who had been operated on four years ago by another surgeon. At the second operation Mr. Taylor found that practically the whole of the uterus appeared to have been retained by the patient, as the appendages of both sides were discovered beneath the greater mass of tumour. Mr. Taylor removed the tumour with the whole of the uterus and the appendages. He does not describe in detail the relations of the tumour to the uterus, whether it was uninodular or multinodular; nor, indeed, does he give any reasons why the uterus and the appendages were removed with the tumour. There may have been good reasons, but they are not given.

It happens that the first operation was performed by me on July 18th, 1892. There was a uninodular mass attached to the fundus by a good thick pedicle, which I clamped in the ordinary way. The ovaries, tubes, and the uterus were perfectly healthy, and in accordance with surgical rule I left them.

In his description of the case¹ Mr. Taylor says she was much disappointed at the result² of the previous interference, and this may be true of the patient, but it is a very mild description of the position taken up by a relative who accompanied her in a visit to my consulting rooms just before she was placed under Mr. Taylor's care. The attitude of the latter was that I was to blame for not operating, so that a further growth of tumours should have been prevented. Of course the evident answer to this absurd complaint was threefold: First, that regrowths of myoma under such circumstances are to me a wholly new experience. A suggestion that it might occur would of course have to be entertained, but that it ever had occurred up to that time required proof. The second answer: Why should I have removed a perfectly healthy uterus and set of appendages in a young woman of 28, seeing that our rule is, and always has been, against such a proceeding? We might just as well expect complaint that a surgeon had not amputated at the hip-joint for a crushed tarsus because two years after the patient got a badly-crushed thigh. Thirdly, who would dare, after our experience of the actions against Dr. Cullingworth, to remove

healthy organs in such problematical contingency as the one before us? Verily the surgeon's lot will in future be a most unhappy one if he runs risk of action at law on the one hand for removing healthy organs, and on the other hand of being abused for not removing organs in which no trace of disease existed. In any event, these two cases of Mr. Taylor's contribute not a scrap of evidence in support of the contention of Mr. Bowreman Jessett. The materials for a full discussion of the respective merits of the two ultimate alternatives for the treatment of the myomatous uterus are not yet in existence, and both patience and care must be exercised till they are obtained.

REFERENCES.

¹ *Medical Press and Circular*, February 3rd, 1897. ² Of course Mr. Taylor is mistaken here in the word he uses. The second growth was a *sequence* of the first operation, but in no sense a *result*.

A CASE IN WHICH THE TONSIL, FLOOR OF MOUTH, AND HALF THE TONGUE, WERE REMOVED BY EXTERNAL PHARYNGOTOMY FOR EPITHELIOMA.

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I WAS induced to undertake the very extensive removal of malignant growth in this case by a study of the records of similar operations in Mr. Watson Cheyne's *Letsomanian Lectures* for last year. The important points in connection with the operation are so fully discussed in those lectures, and such a complete table of the recorded cases there given, that I need do little more than relate the details of my own case.

Secondary hæmorrhage has so often followed ligation of the external carotid artery in what cannot be an aseptic wound (as it communicates freely with the throat) that I decided not to tie this vessel, but to divide and turn apart the divided portions of the lower jaw, so as to gain free access to the tonsillar region for the purpose of dealing readily with all bleeding vessels. I did not simply drain the wound with a drainage tube, but packed it with cyanide gauze, as is usually done after Kocher's excision of the tongue.

To feed the patient by a tube passed into the stomach and left there is also, I think, a very great advantage, as no food gets into the mouth, and painful and difficult attempts to swallow are not necessary; moreover, the patient at once begins to take large quantities of liquid nourishment. Before operating in this case, I used this method of feeding the patient in a case of Kocher's excision of the tongue and floor of mouth, and at the present time I am employing it in a case of excision of the body of the lower jaw and tongue, and in both cases with great advantage. The patient now under my care, on the third day after the operation, was taking four pints of milk with brandy and beaten-up eggs in the twenty-four hours, without any difficulty or discomfort. In using this method I followed a suggestion of Mr. Arthur Barker, given in his record of a case of Kocher's excision of the tongue, published in 1887. The tube (which should be about the size of No. 14 of the œsophageal tubes) is apt to get blocked with milk curd, and to prevent this it is well to syringe a little water through after each time of feeding.

T.J., aged 55, came under my care at the Bristol General Hospital, on June 3rd, 1896, with a history of a "pricking soreness" at the back of his tongue and in his throat, which had only been present for five weeks. At the time he came under observation he could only swallow liquids, and those only on the left side of his throat, and with much pain and difficulty. Inspection of the interior of his mouth showed a hard, ulcerated, warty growth on the back of the right side of the tongue, which involved the floor of the mouth between the back of the tongue and the jaw, and the junction of the tongue and anterior pillar of the fauces, and extended on to the tonsil. There was only one enlarged submaxillary gland to be felt. When under the anæsthetic at the time of the operation I felt the hard growth in the tongue extending to the middle line, and was just able to get the tip of my finger below it, down the pharynx.

Operation.—The operation was performed on June 12th. I first opened the trachea and inserted a Hahn's cannula, and