RESULTS OF SUPRAVAGINAL HYSTERECTOMY, WITH REMARKS ON THE OLD WAYS AND THE NEW OF TREATING UTERINE FIBROIDS.

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I HAVE already published in detail every case of supravaginal hysterectomy performed by me till the end of 1884. The mortality was 7.9 per cent. I have also given every case in which I have in any way interfered with a uterine tumour by abdominal section. No one has done this but myself. With the exception of a case of very large solid tumour, probably uterine, in a girl of 16, operated on in hospital for Dr. Skeen, of Brooklyn, the list of hysterectomies is carried down to date.

The mortality is greater than before, and it differs much in hospital and private work. In this series all patients operated on outside the hospital recovered; the fatal cases were all in the hospital. Of the whole series of sixty-four cases, twenty-six were private cases, with a single death (3.8 per cent.), and that patient died of acute mania. Of thirty-eight hospital patients, six died, or 15.7 per cent. In the private cases the tumours were larger; for private patients, being more able to take care of themselves, do not need interference so soon. They were also much more drained by hæmorrhages, and were altogether in a less satisfactory and more anxious state than the majority of the hospital cases. I may here mention that, in ovariectomy, the same great difference obtains between private and hospital practice. In the first three years of hospital work, when everything was fresh and new, the mortality after all operations—not including spray cases—was under 2½ per cent. Since then, that is, during the last three years, erysipelas has conveyed into the rooms, and has broken out three times. Pneumonia, which seems to be endemic, has appeared three times. The mortality has risen from under 2½ to 5½ per cent. It is but fair to say, however, that the number of severe and advanced cases of ovarian tumour continues, and that patients are, as a rule, not sent in an early stage, as they seem to be elsewhere. During more than these three years, a single death from diabetic coma, following a simple ovariectomy, which was rather advised against, sums up the whole mortality in private practice. All these operations were performed in crowded hotels, private houses, or ordinary lodgings.

Of the whole number of hysterectomies, five suffered from acute mania. When the attack followed quickly on the operation, the patients died; coming on later during the convalescence, recovery took place. A sixth, a young woman who was operated on at 19, was brought to me some years after, thin, morose, and useless. Such a number of cases of mania following this operation cannot be an accidental circumstance.

The average time of convalescence in the extra-peritoneal cases was forty-one days; of the intra-peritoneal method, three weeks. There was no death either in hospital or private practice when the intra-peritoneal method was followed out, and I am satisfied that the best results in hysterectomy will be got by the ligature. Though a more surgical, this is a more difficult way, and much care is needed in tying the vessels in the treacherous tissue with which we have to do. The principle of the extra-peritoneal treatment may seem to be the better, considering the amount of tissue that has to be left inside; but on this point experience has made me change my mind. We owe much to the extra-peritoneal or clamp method, for it was to the faithful carrying out of this principle by Sir Spencer Wells that ovariectomy was established as a legitimate operation; and though it did not at first give the best results, just as it is not now giving the best results in hysterectomy, this was mainly because in those days the means at our disposal were insufficient to disinfect the stump. These things are apt to be forgotten.

The tumours removed were smaller than before, and in all the fatal cases the operation was begun with the intention of removing the ovaries only. It was impossible to find them or to remove them

sometimes even after the tumour was turned out. In two, where omental adhesions were separated, and in another, where a rent in the substance had taken place on the tumour being got out of the pelvis, bleeding from the surfaces was such that there was no help for it but to go on. The proper practice where the ovaries cannot be entirely removed in cases of moderate-sized fibroids is to close the wound; for, though we may be warranted in advising a patient to run a small risk in getting the ovaries away, we are not justified in at once putting her into the risk of hysterectomy without her full consent. I regret much that I did not close the wound in Case 59, where the local conditions were not favourable for hysterectomy performed in a surgical hospital. Since then I have done no case of hysterectomy in the hospital; the only hospital case where interference was necessary was operated on in a lodging in August last. It was probably the most difficult operation I ever performed. The hæmorrhage from the bottom of the pelvis and side of the rectum was almost uncontrollable, and she nearly died on the table. Fortunately she was treated intra-peritoneally, and was going about in three weeks. A number of others have undergone or are now undergoing Dr. Apostoli's treatment. No one has suffered from the delay. Indeed there is rarely any hurry in interfering with uterine fibroids by operation.

I say it deliberately, hysterectomy is an operation that has done more harm than good, and its mortality is out of all proportion to the benefits received by the few. What is the mortality of this operation, now so often and so unnecessarily performed? We shall never know. I put it at 25 per cent., though it is probably much higher. I may be wrong; others can correct me by giving their total results. In other words, one out of every four women operated on by hysterectomy has till now died after an operation for the removal of a tumour that has, as a rule, a limited active existence, and that of itself rarely shortens life. We have no right to rush our patients into such a fearful risk, yet this is done every day. In abdominal surgery responsibility seems to have become old-fashioned and gone out of date.

When the whole stroma of the ovaries can be removed, the proceeding is so simple that it is scarcely worth calling it a surgical operation. Unfortunately, there are exceptions. When the ovaries are too close on the tumour, or when they are buried in the broad ligaments deep in the pelvis, or drawn behind the tumour, and cannot be satisfactorily removed, then failure is certain. The patient has the misery of the operation for nothing; the hæmorrhages and growth go on as before. In every case where the ovaries have been entirely removed the cure has been perfect; cessation of growth and stoppage of menstruation have been the invariable results. In two cases of imperfect removal no good whatever followed; one of these has since, I may say, been perfectly cured by Apostoli's treatment; the other is now being treated in the same way. In two others, where the ovaries were removed, where part of a large submucous fibroid was projecting into the vagina, enucleation had, after all, to be performed, with successful results. The ovaries might thus have been spared in these two cases, and one of the patients bitterly regrets every day her loss of them.

Enucleation has given me the smallest mortality of all the various methods for the relief of uterine fibroids. Indeed, on only two occasions has death followed this operation, and I have performed it a great many times. It is to my mind the most difficult of all operations on the uterus. In the first of the fatal cases, the mass, removed in pieces, weighed seven pounds; slight sloughing had begun after many previous attempts to remove the tumour before I saw her. There was hæmorrhage an hour after I left, and she died a week after of septicæmia. In the other, a patient sent by Dr. Cruickshank, the tumour enucleated was not larger than a child's head. She was perfectly well on the third day, when the antiseptic plugging was removed, then died suddenly of septicæmia. I did not know till long after that she lay on a bed on which a patient had just died of pyæmia. The room had been papered afresh, and the carpet and mattresses were new, but the blankets had not been washed. I mention these two deaths after enucleation, for the general impression seems to be that this is the most dangerous of all the methods for removing uterine tumours. I have not found it so. There is a secret in the doing of it, for it is not an obstetric operation that may be performed with all the apparent roughness of a craniotomy. It is a difficult and delicate surgical operation, requiring a thorough knowledge of scissor work, such as experience in vaginal plastic operations can give. Then it must be completed at one determined operation. If the ovary be not open enough, it must be freely divided, and the parts afterwards united by suture. The most rigid antisepsis is essential. It requires greater care, greater patience, and greater endurance than any operation I know.

Fortunately for those afflicted with uterine tumours, it now matters little which of the old ways of operation is the best; whether the ovaries can be removed or not, whether the extra- or intra-peritoneal method be the better way of performing hysterectomy, or whether the convalescence lasts in the one case six weeks, or in the other twenty days, the treatment introduced by Dr. Apostoli must take precedence of all others. The success of this treatment is a great fact, and in saying that I accept *totò animo* his teachings, I do not speak without some experience of his practice. We have already—my son and I—in scarcely five months, applied electricity in strong, accurately measured doses upwards of 1,200 times, in considerably more than over a hundred patients, the majority in cases of uterine fibroids. The labour has not been small—indeed, it has been very hard—and it is not easy to get the science of the subject into an old head. On the other hand, it has opened out a delightful study, which increases in interest every day the deeper we get into it. When I came back from my holiday in the beginning of July, there were waiting for me several cases for hysterectomy or for the removal of the ovaries for bleeding fibroids, and there have been others since. These have all gone home without operation, with menstruation almost normal, and improving after their return, with the tumours in every case reduced in size, with pain gone, and with a freedom to walk about and enjoy life such as they were long strangers to. In one case only has there been a return of hemorrhage. The tumour had gone down two-thirds, she was apparently well, and, unwilling to detain her longer in town, she was allowed to go home too soon. All were more than pleased to have escaped the risks and miseries of a surgical operation that at once put their lives in peril. We—every one of us—consider far too lightly the misery that such operations cost our patients and their friends.

Should these improvements be permanent (and we have Dr. Apostoli's word for it that if the treatment be carried out long enough such is generally the case, and, so far, I am able to endorse almost every statement that he has made) it follows that the field for hysterectomy for the removal of ovaries for fibroids is narrowed down to the smallest limits. I have never been in favour of hysterectomy, simply because its death-rate is so high, and because it is performed for the removal of a tumour that rarely kills. So strongly do I now feel on this subject, that I would consider myself guilty of a criminal act were I to advise any patient to run the risk of her life—and such a risk—before having given a fair trial to this treatment, even were I sure that the mortality would not be greater than that which hysterectomy has given me in my private cases—under 4 per cent.

Twenty-Six Cases of Hysterectomy.

Number.	—	Date.	Age.	Weight.	Remarks.	Result.
39	Hospital	Jan. 1885	40	61	Ovaries could not be removed	Died
40	"	April "	37	63	Ditto.	Recovered
41	Dr. Coleman	Sept. "	40	19	No adhesions	"
42	Hospital	" "	41	3	Ovaries could not be removed	"
43	"	Oct. "	38	21	Ditto.	"
44	Dr. Young	" "	37	12	Omental adhesions	"
45	Dr. Gowans	Nov. "	26	1	No adhesion—uterine cavity not opened	"
46	Hospital	" "	28	6	Omentum and colon adherent	"
47	"	Dec. "	34	11½	Omental adhesions, and to large intestine	"
48	"	" "	42	—	No adhesions	"
49	"	Feb. 1886	38	10½	Ditto.	"
50	"	March "	30	10	Deaf and blind from anæmia—kidneys diseased	Died
51	"	April "	29	11½	Parietal and pelvic adhesions	Recovered
52	"	" "	39	8	Ovaries could not be got at—formerly insane—acute mania	Died
53	Dr. McVail	" "	38	20	Heart pushed upwards—frequent attacks of syncope	Recovered
54	Hospital	May "	40	8½	Broad ligaments largely opened up	"
55	"	June "	40	4	Ovaries could not be removed	"
56	"	Aug. "	40	3½	Ditto.	"
57	Dr. "	" "	38	19	Broad ligaments opened up	"
58	Hospital	Dec. "	45	13½	No adhesions	"
59	"	Jan. 1887	37	4	Ovaries could not be removed	Died
60	Dr. Lightfoot	Feb. "	38	3	Very extensive omental and intestinal adhesions	Recovered
61	Dr. Young	April "	51	20	Omental. Cavity of uterus occluded and distended by fluid	"
62	Dr. Moore	" "	29	5	Very firm pelvic adhesions	"
63	Dr. Whyte	" "	29	—	Sarcoma of body of uterus	"
64	Dr. Wallace	Aug. "	38	5	Very firm pelvic adhesions—ovaries large and very adherent.	"

NOTES

ON

AN EXCEPTIONAL CASE OF APHASIA.

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THE patient was a clergyman of studious, temperate and somewhat sedentary habits, and of the highest intellectual powers, with singular gifts of speech, preaching, and lecturing extempore, with rapid delivery, never hesitating for a word, and yet never wanting in exactness. He worked unsparingly, writing much. His temporal arteries were prominent and tortuous. He was 64 years old at the time of his first seizure. He was found shortly before 8 A.M., sitting on the side of his bed, rubbing his right leg, conscious but quite speechless. After an hour he had recovered the power of saying "yes" and "no," but no other words. His right hand and arm were paretic and ataxic. After nine hours the ataxy was less marked, and he could manage to speak a short sentence. Next day his power of speech seemed quite restored, and there were scarcely any traces of the paresis or ataxy.

After this attack, he abstained for a time from work; but, on returning to it, was not so perfectly fluent as formerly in preaching. A second seizure occurred nearly 2½ years after the first. This, like the first, occurred before 8 A.M., soon after his leaving bed, and before he was dressed. He was heard to fall in his dressing room, and his wife, going to him instantly, found him unconscious and muttering; but in a few moments he completely recovered consciousness and speech. When I saw him half an hour later I found paresis, ataxia, and impaired muscular sense in his left arm. He had not the slightest difficulty in expressing his thoughts, and inquired in a tone of surprise, "Where is my left arm?" It was out of his sight, being turned back under his head on the pillow. After seven hours the ataxia was no longer perceptible, and the next day he was convalescent. After this attack he reduced his work, gave up his church preferment and preaching, but continued his writing, chiefly by dictation, on abstruse subjects, and with force and clearness.

Passing over events which have no immediate connection with aphasia, we come to his third and last seizure. This occurred nearly three years after the second. It was a violent attack of cerebral hæmorrhage, occasioning complete paralysis and analgesia of the right side, almost entire loss of sight and hearing, consciousness being wholly suspended for some days, and afterwards very imperfect. He lived three years after this attack, but never again spoke an intelligible word, except on one occasion, "Do, do," when apparently becoming conscious of his inability to move his right leg. He sometimes talked—if it may be called talking—long and earnestly, with modulation of voice and expression of face as if he had conception of what he was uttering, but in the utterances was no articulate or intelligible word. Though sight and hearing were impaired, he preserved the sense of taste. After two months sensibility was restored in the right hand, and some power of movement.

He was kept alive by skilful and tender nursing, but the right arm became contracted, and two and a half years after the last seizure he nearly died of pneumonia (left). After this his strength and nutrition failed, bedsores formed, contracture came on in both legs, most marked in the right; respiration was often of the Cheyne-Stokes type, and six months after the pneumonia he died exhausted.

The point of special interest has yet to be mentioned. This gentleman was naturally left-handed. Yet, as the narrative shows, his aphasia accompanied right hemiplegia, and did not accompany the left hemiplegic attack. In this the case differs, I think, from any yet recorded. The general fact has been that aphasia has accompanied paralysis of the preferentially used hand, accompanying right hemiplegia generally, left hemiplegia rarely, and then only in the cases of left-handed persons. In the case related, the aphasia followed the ordinary rule of right-handed persons, though the patient was naturally left-handed.

The explanation of the anomaly may, I think, be found in the fact that, though left-handed for other actions, he wrote with his right hand, and was in the habit of writing much. It was not due to any association between speaking and gesticulation, for he had not the habit of gesticulating.

The case has a bearing on the debated question whether the ordinary location of the faculty of speech in the left cerebral hemisphere