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Supravaginal Hysterectomy for Carcinoma Uteri.

This operation is at present young in the annals of Surgery but it is growing fast in reputation & gives promise of obtaining an honourable place in the list of serious modern gynaecological operations.

The disease is desperate & therefore we cannot feel surprised when a desperate remedy is proposed Supravaginal Amputation very rarely totally eradicates the disease & can justly be termed no more than a palliative measure. Prof. Freund of Breslau was fully impressed with this fact when he introduced the operation of Total extirpation of the Uterus by Laparotomy an operation preeminently fatal & only justified by the deadly nature of the disease & the occasional

recovery of a patient by its means.
Schroeder in 1878 stated that if the
disease should return four times out
of six he would still operate.
When so many of the leading
gynecologists can be found to
support & perform an operation like
Freund's it shows conclusively that,
from a clinical point of view,
supravaginal amputation in the
hope of eradicating the disease is
futile besides being frequently fatal.
What is the clinical experience of
the general surgeon, if he has to
deal with a cancerous growth in
the substance of a muscle in any
other part of the body he knows
that to insure any hope of a
non recurrence he must remove
the whole of that muscle, this
surgical principle is arbitrary &
holds as well for the Uterus as
for the Sartorius, we have yet to
learn that Unstriped muscle differs
from striped in this respect, + in

the case of the uterus there is the more reason for obeying this rule in that if in an incomplete removal the growth return there is the less chance, practically no chance, of a second operation being of any service.
Again the clinician is in this matter supported by science
Abel gives it as his opinion that in all cases of cancer of the cervix where the endometrium is affected with cancerous disease. Archiv für Gynäk., Bd. XXX., Hft. 2.
If this opinion is correct how can any partial operation be considered in any sense curative?
Fränkel, although disagreeing with Abel as to the condition of the endometrium yet on general pathological ground approves total extirpation in preference to supravaginal amputation.
Metastases are occasionally formed in the substance of the uterus when of course the amputation of the cervix would be absolutely futile.

The removal of the entire uterus by laparotomy was accompanied by such a high mortality, 72 per cent. that it was no surprise to the profession to hear that Dr. Schroeder had introduced the only other method of extirpating the uterus namely per vaginam. The first statistics published of the results of this operation gave a mortality of 28 per cent, but I do not intend dealing with the uncertainty inherent in statistics. In March 1865 the subject of supravaginal extirpation of the uterus was discussed by the Obstetrical Society of London & only two surgeons were found to say a good word for it but they & their opinion are such a subject is not to be despised. Sir Spencer Wells & Dr. Greig Smith. Since that time the operation has become better known in England & it has been modified & improved by Prof. Sinclair whose method I have had the pleasure of working. I now intend to make a

number of cases & to make a few remarks on the method of operation & the condition under which it should or should not be performed.

Case I. Under the care of Mr. E. Stanmore Bishop M. S. aged 42; married, 6 children, no family history of cancer. Had good health until February 1895 when she had a severe flooding which was supposed to be a miscarriage & has since had intermittent discharge, losing flesh, strength, pain over the sacrum.

Present condition. There is constant discharge of blood stained, foul smelling fluid from the vagina constant pain in back & thighs With the speculum a cauliflower growth is seen filling the upper part of the vagina & bleeding on touch springs from the os uteri. Bimanually the uterus was found to be movable but not freely. There was no fixation to bladder or rectum, vagina well dilating. The discharges were epithelioma of the cervix uteri.

On October 7th 1889 the operation was performed by Mr Bishop. The growth was found adherent only by the apex very little of the cervix remaining, irrigation with a hot saline solution was maintained throughout the mucous membrane was divided all round the os. The recto vaginal septum was divided with scissors & a soft sponge inserted on a stick was passed behind the uterus. The bladder was then separated from the uterus in front & the vesico uterine fold of peritoneum opened, another sponge was pushed through this opening. The left broad ligament was then tied & divided The process of tying on the right side was very difficult owing to the friability of the tissues & two Spencer Wells forceps had to be left on, after plugging the vagina was packed with iodoform gauze & a catheter left in the bladder. The operation was followed by much shock.

Oct. 9th Tuesday the packs were removed - a small drainage tube was inserted & packed round with iodoform gauze. Until the 11th the patients condition was not very

retrospecting during the menses of cystitis after this she did well, all the stitches were removed by the 22nd & she was discharged well Nov. 2nd. This case was reported in the Lancet Jan 18, 1890. Mr Bishop tells me that the disease has returned a short time after publication.

The following ten cases were published in the Practitioner Vol XLIII. No 6. They are Mr Sinclairs first cases

Case II E.W. aged 39 admitted into the Manchester Southern hospital Aug 5th 1882. For many months she had been suffering from profuse irregular haemorrhage from the vagina & was very anaemic. Vaginal examination revealed the presence of a fungous growth of the vaginal portion of the cervix which bled profusely when touched. There was also a constant offensive discharge. The diagnosis was epithelioma of the cervix. The operation was performed on Sept 12. 1882 The plan adopted was that described by Madden. The bladder was first partly separated from the uterus the iliac vesico uterine ligament incised

An opening was then made into Douglas' pouch the tumour was forcibly brought down behind & the broad ligaments then tied from above downwards firstly the separation of the bladder from the Uterus was completed & the Uterus removed.
During the operation the bladder was wounded The peritoneum was stitched & a perforated tube inserted into the vagina She died 20 hours after the operation.
At the post mortem examination a small opening was found in the bladder, the ureters were both intact, the ligatures were all intact, no haemorrhage occurred after the operation. This was the first operation of the kind performed in England.
The next case was operated on after the manner of Fritsch of Breslau.
Case II. E.R. aged 47. 5 children. admitted into Southern Hospital October 26. 1885
The examination & history led to the diagnosis of malignant ulceration with excavation of the cervical portion of the Uterus. The Uterus was quite movable &

The operation was performed Nov. 6. 1885
every step of the operation was easy
except the forcible complete version of
the uterus. For the first few days
she did well but disturbance of
the function of the kidneys occurred
& she died Nov. 13. At the post mortem
it was found that the left ureter
was tied & cut, there was an abscess
behind the right ovary & there were
other signs of peritonitis.
Dr. Sinclair then devised a method
which he has practised ever since.
Case IV This was an incomplete operation
& was little more than a supravaginal
amputation owing to the cancerous state
of the cervix. J. B. aged 48. 7 children
Profuse offensive discharge of 3 months
duration, patient pale & cachectic
Uterus enlarged but movable, disease
affecting the cervical portion. The operation
was performed Aug. 2. 1887. The anterior lip
was separated from the bladder & ligatures
in several places to stop haemorrhage.
Douglas's pouch was then opened. An attempt

was then made to the parametrium on both sides step by step beginning from below but it was necessary only for a short distance on either side as the disease had reached the sides of the pelvis & the portion of the ureter completely enclosed was cut away & the operation finished with comparative ease. She made a good recovery from the operation but is reported to have died on October 22nd.

Case V. E.A.J. aged 31. 4 children. During last pregnancy she had irregular haemorrhages which continued after parturition i.e. twelve months ago since then she has had bleeding almost every day. Patient is anaemic. The upper part of the vagina is found to be filled with a large nodular irregular mass which on more exact inspection appears to be a hypertrophic epithelioma of the vaginal portion of the uterus. The uterus seems immovable. The tissues behind on the right are infiltrated. The ureteric process does not extend to the vagina. The operation was per-

formed on Sept. 27. 1887 under constant
irrigation of the field of operation
with antiseptic solution of 1 in 5,000
The operation was carried out almost entirely by the method which has of late
acquired a certain reputation was
quite satisfactory. The ovaria were left
alone. The vagina was packed with
iodoform gauze. Two notable things
occurred in the first 24 hours (1) the
vaginal tampon became thoroughly soaked
& the fluid oozed through it till it
stained & soaked the outer dressings
& (2) the amount of urine was extremely
scanty, only 4 ounces in the first 12 hrs
& the same in the second. Thirty hours
after the operation the tampon was removed
& a wide rubber tube inserted packed
round with gauze. The patient made
a good recovery. The stitches were removed
Oct 14th. She was quite well in December
Case VI. E. P. aged 31. one child. 8 mis.
carriages last one in March 87. Patient
is of florid type but anaemic has
pain in the sacrum & profuse offensive discharge

which has continued ever since the miscarriage in March. No history of cancer. Per vag examn a soft shaggy mass evidently cauliflower excrescence was felt projecting into the vagina attached to the lining of the cervical canal, only slightly invaded the portio vaginalis. The whole uterus perfectly movable. The operation was performed on Dec 21 in the same way as in the last case (1887) with slight but essential modification. The chief of these were (1) The use of Paquelins cautery to check bleeding from mucous membrane & peritoneum in order to diminish the number of ligatures. (2) No preliminary partial ligation of the parametrium was attempted. Traction was intermittent. In closing the wound two prepared sponges were left opposite each broad ligament stump & a drain tube placed between but when the wound was closed on the 3rd day these removed easily & painlessly. The last ligatures came away Jan. 12. 88. In Sept. 89. the patient was strong & well.

Case VII. This was a case of cancer of the body of the uterus simulating sloughing fibroid but which was afterwards proved to be cancer by microscopic examination.

E.M. 48 single first seen in the summer of 1886 very anaemic with symptoms of profuse offensive discharge & haemorrhage more or less very deep & hypogastric pain. The os was almost on level with vaginal roof & the lips thinned out, uterus large, round feeling 3½ inches & cause haemorrhage, an irregular nodule was brought away with the curette. After this she was better until early in 1887 when all the symptoms returned but were again relieved by curetting but soon again returned after some delay the operation was performed Jan 2. 1888 The pelvis was small & the vaginal canal & diaphragm was experienced in applying the ligatures & afterwards in retracting the uterus when cut away. The vagina was packed with Iodoform gauze which was not changed until Jan. 6. In August 1888 she was quite strong & well

Case VIII. E.W. aged 51. 8 children.
Admitted into Sowton Hospital March 1. 85
Patient first felt pain in November 1884
Pain in defaecation. Foul smelling profuse
discharge & frequent haemorrhage, very
anaemic almost cachectic. Disease was
neither advanced epithelioma of the cervix
but the mobility of the uterus was good
The operation took place March 9. 85.
& was performed in the same manner.
She never had a bad symptom. The
first dressing was on the 16th seven days
after the operation & the last stitches
came away on the 29th.
Case IX. E.H.J. aged 53 seen in April 1885
History of haemorrhage for 15 months with
pain in hypogastrium. The disease
was found to implicate the cervical
canal the uterus was large & the
os was intact. The uterus was fairly move-
able. She was very anaemic. The operation
was performed May 6th There was not
much difficulty except in separating the
uterus from the bladder where a much
hole was made in the latter this was

stitched & the wound drained in the usual way. Did well until the third day when the catheter was to have been pushed through the wound in the bladder & the latter collapsed & died the following day
Case X. M. E. J. aged 43 single. First seen May 10. 1889 She was thin & had menstruated too frequently for nearly a year & for the last four months there had been an offensive dirty discharge. The urine was normal in sign & quite movable. She was noble & female & there was profuse hæmorrhage on scraping it with the finger nail, there was very little ulceration. The operation was performed on May 18th when it was found that the disease had very much increased. At the termination of the operation some emetine hydrochlorate was to be pushed back. The temperature & pulse went up after the operation & the next day the wound was drawn & a drainage tube inserted. She died on the 23rd. In this case I made a post

morbid examination & found perforation
a small part of ileum in the most dependent
part out of reach of the drainage tube
The right kidney was full of small
stones & one large one.
Case XI. J. M. aged 41 two children
For 6 months there has been profuse offensive
discharge, bleeding for two months. The
uterus was very large, quite movable, the
vaginal portion was ulcerated as was part
of the vaginal wall. Before the operation
which was performed June 26 the temperature
went up one day to 101°. The operation
was tedious owing to the size of the
uterus & the amount of vaginal mucous
membrane that had to be removed
The endometrium was found to be thickened
hypertrophied & of a dark purple colour
I took some for microscopical observation
but could find no distinct signs of
cancer. I ask the cause of her recovery
she suffered from frontal which at
first gave some alarm the temperature
rising very high. She is now well but
the vaginal mucous membrane is unhealthy.

Case XII. S.H. aged 33 married. 0 children one miscarriage eight years ago. Has been ill 12 months. The first symptom was that of haemorrhage occurring nearly every week accompanied by severe pain. The discharge is sometimes watery & of late has become offensive. The discharge has increased the last 3 months & she has grown much thinner. An aunt died of tumour of the womb. She was admitted into the Southern Hospital Oct. 22, 89. The operation was performed Oct. 24 there being no doubt about the diagnosis of cancer. The left ovary which was cystic was removed but the right was too adherent to be detached. A pair of forceps was left on one bleeding point. After the operation the temperature rose but the pulse remained steady. The forceps were removed the next day & there was no haemorrhage. The dressings were removed for the first time Nov. 4. the eighth day. After this the temperature frequently rose rather high particularly on one occasion when it suddenly rose to 109° accompanied by a severe rigor this may have been caused by an enema but

more probably by contamination with a septic case in the next ward, for after this the temperature never rose above 100°. The stitches were removed Nov. 16. 85. She was discharged well Dec 2. 85.

Case XIII. B. M. aged 23 married 2 children Committed into the Samaritan Hospital Oct 24. 85. Last child was born 5 mos. ago & ever since she has had pain in the back & an offensive discharge. There was undoubted epithelial cancer of the cervix. The operation was performed Nov. 6 The uterus was removed with both ovaries & was attended with much depression & sickness. Nov. 7. The pulse & temperature having both risen to 130 & 104° respectively abdominal section was performed this evening & the abdominal cavity washed out with saline solution. On Nov. 8th There was no improvement & she slowly sank & died on the morning of the 9th of November. She died of acute septicaemia.

Case XIV. A. C. aged 35. married 2 children. Has had an offensive watery discharge for the last 8 weeks with slight pain in the back, menstruates every fortnight

She was admitted Dec. 26. 89 & the
operation was performed Jan. 8. 1890
after the return of the disease was fully
ensured. The operation was normal although
owing the symptoms occurring, a good deal
of shock followed from which however
she soon recovered. She was allowed for
the first time Jan 16th. All the stitches
were removed by Jan 25th. & her recovery
was complete except for some weakness
of urine which afterwards proved to be
due to a fistulous opening in the bladder.
Case XV. A.M. aged 41 married 11 children.
admitted April 10. 1890. Had been ill 9 months
The first symptom was haemorrhage & pain
chiefly when at rest, on examination the
cervix was found to be excavated with
cancer but the uterus movable. The operation
was performed April 12th. but there was found
to be some extension of the disease into
the tissues between the uterus & the bladder
on April 18th urine was found to be coming
from the vagina & a catheter was then into
the bladder. Since doing well. This case
is still under observation in the Hospital.

Case XVI. E.W. aged 47 married 7 children.
Menopause occurred 18 months ago last 6 months
ago she began to have haemorrhage very much
with clots & in the intervals she had much
white discharge but no pain. She lost flesh
& suffered from cold sweats. only for the last
3 months has she suffered from pain in the left
lumbar region. On examination a cauliflower
excrescence about the size of a walnut was found
on the anterior lip of the cervix, the uterus was
not very freely movable. The operation was
performed April 5th 1878 the uterus was removed
but difficulty was experienced owing to some
infiltration of the right broad ligament
The wound was closed for the first time
April 18th & all the stitches came away
on the 20th when the wound was looking
very healthy. This case is still under observation.
The last five cases were operated on
by Dr. Sinclair but have not as
present been published in any of
the journals, he has done two other
cases which were very successful but
I am unable to give the notes of
them. The next two cases were

operated on by Dr. Donald of
St. Mary's Hospital Manchester & he
has kindly sent me the notes of
them, they have not been published
Case XVII E. L. aged 28 single
admitted October 15th 1888 Complained
of profuse watery discharge which was
offensive, constant during the last
three months, no pain, no menorrhagia
Physical examination: Cervix is replaced
by large sprouting friable mass
in the centre of which the os uteri
can be felt, bleeds freely on being
touched, no infiltration of the
broad ligaments. Operation Oct. 25th
Semicircular incision in anterior
fornix of vagina - uterus then separated
from the bladder by means of fingers
then peritoneum opened in front of
Douglas's pouch then opened into.
Broad ligaments tied in section
from below upwards. No forceps used
No stitching of vaginal vault
Dressed with plugs of iodoform gauze.
Patient had no pain after operation

Highest Temperature 100° on the night after the operation. Drugs removed on Nov. 1st & Nov. 4th. Discharged Nov. 20th Vault of vagina shows small cicatrix which seems firm & healthy. Returned March 22. 1880 Cicatrix has undergone proliferation & bleeds on being touched - Patient who was very stout & robust on being discharged is beginning to lose flesh & complains of pain in the pelvis. April 18th Letter from patient who has returned to her home in Germany to say that she still has pain & discharge but her general health keeps fairly well.

Case XVIII. E.C. aged 32. married. nine children. Symptoms date back twelve months. Complains of copious watery foetid discharge & attacks of menorrhagia of late very profuse. Very cachectic. Locally, cancerous mass is situated in cervix which it has opened out - Runs up to os internum. Rectum & bladder appear

free & no infiltration can be felt
in the broad ligament.
Operation Jan. 22nd 1896. In similar
manner to the preceding case - one
of the ligatures slipped from the
broad ligament after dividing the
tissue & there was very free hæmorrhage
but this was controlled by another
ligature. Apart from this accident
the operation was free from difficulty
or complication. Patient never rallied
to really from the operation, She com-
menced to be sick on the same
day & vomiting continued throughout
There was no diarrhœa or hyperpiexia
& she was quite sensible & free from
pain. She gradually sank & died on
Jan. 27th or the 6th day after operation
It should state that the only cause
which could be assigned for the
fatal result was that the cachexia
& anæmia were too far advanced
to permit of the patient rallying after
operation. If hæmorrhage had not taken
place during the operation perhaps the

result might have been different.
I have purposely limited myself
to records I have performed in Manchester
& with the two exception I have
mentioned they are all the cases that
have been done & I think that the
results augur well for the future
tho' operation of this kind cannot
be expected to show triumphant
results. Operations learn only by their
mistakes & the greatest mistake that
we can do is that
of operating on unsuitable cases.

The Method of Operation

I will now give nearly in his own words the method employed by Dr. Sinclair as it is by his method & the other cases I have cited have with slight modification been performed. As House Surgeon of the Southern Hospital I have had the privilege of assisting in the general arrangements & of watching the course of many of the cases I have related.

The external genitalia are shaved & thoroughly washed with soap & water & then with a disinfectant. The operating room is sprayed with carbolic for some hours before the operation. The patient is anaesthetised & placed in the lithotomy position & is kept in that position by leg holders & by two nurses who support a leg with one arm & have the other free to hold anything that may be required. The operator sits on a low stool in front of the patient & introduces a short broad

speculum. The field of operation is then thoroughly swabbed with a strong solution of Corrosive sublimate 1 in 500 & a pledget of cotton wool wrung out of the same solution is pushed into the canal of the cervix. Constant irrigation is kept up during the operation with a hot solution of corrosive sublimate 1 in 5000.

(1). Separation of the Ureters from the Bladder. The anterior lip is seized with strong vulsellum forceps & pulled forwards & downwards by one of the assistants. An incision is now made across the front of the cervix, keeping as near the bladder as is safe. The position of the bladder is rendered evident by means of a curved sound. The incision is not made with a single sweep of the knife but a slight ligature is firstly put through & tied & then the mucous membrane is divided. All the ligatures employed are cut long & held out of the way.

The bladder is then separated from the uterus by means of the index finger or of the handle of a scalpel no some difficulty is sometimes met with in effecting towards the sides a clean separation, owing portions of tissue may be caught up by means of an aneurysm needle armed with silk, with a view of the uterus & divided with scissors on the side next of the uterus. Dr Sinclair uses a specially constructed handled needle slightly curved with a notch about a quarter of an inch from its extremity on its dorsal aspect.

(2) Stop the present haemorrhage. As there is usually considerable oozing from the fungous tumor, the left parametrium must now be dealt with at least of the lower end. The vaginal wall is cut through with the same precaution as in front. The needle is then passed in the same manner through the lower portion of parametrium taking necessary portions of the ligatures tied right &

the tissue so tied is divided on the side next the uterus. The same process is then performed on the right side.
(3) Opening into Douglas's pouch. —
It is now found that with the aid of the numerous ligatures as traction the uterus can be so kept down & the vessels retracted that the speculum can be dispensed with. The vagina behind the uterus is then incised & cut through as in front. The same portion of the partition is then pushed off from the cervix for some distance & then the tissue en caught & held with two pairs of hæmostatic forceps a short distance from one another & divided between them with scissors & the opening so made forcibly dilated by lateral strips.
(4) To diminish the risk of sepsis. —
a specially prepared soft sponge is mounted on a piece of strong silver wire & passed up into the pouch of Douglas through the aperture just made.

(5) Tying the Broad ligaments step by step. — The vaginal wall has been cut all round & the uterus is only attached by the Broad ligaments & the plica vesico uterina of this has not before given way. The index finger of the left hand is now passed through the opening in the pouch of Douglas to the lower margin of the left broad ligament so as to grasp the needle where it is passed through either from before backwards or vice versa taking in successive portions of the ligament, each portion is then tightly clipped with scissors close to the uterus, care is taken not to cut too much tissue after tying each ligature a small part being left to be included in the next, the Fallopian tube being the last. The right side is then treated in the same way & lastly the plica vesico uterina is torn or cut through & the uterus removed The wound is then freely irrigated the sponge removed & the dressing only remains.

(6) Includes the removal of the ovaries & tubes & the irrigation of the field of operation before removal.
(7) Final dressing — By drawing on the whole field of operation in (1) pictures) be brought to view; the parts are then sponged & dusted with Iodoform. The introduction of a Tampon of Iodoform gauze is next begun, the rest of material is carried up nearly to the end of the Fallopian tubes. When this process of packing is partially complete the ligatures are cut, leaving about 3 or 4 inches of each & then the remainder of the vagina is filled with the Iodoform gauze, followed some cotton absorbent antiseptic material.
This then is Dr Sinclair's operation I have slightly abbreviated his text & occasionally put in a detail that he has omitted.
I will now venture to make a few critical remarks concerning this method. In an operation of this kind involving the peritoneal cavity time is of much

importance & I believe that for how much time is wasted in applying useless ligatures. The mass of the disease should I think always be removed if possible before the actual operation is begun & as a rule of any is from the rapidly & imperfectly formed blood vessels that are met in & at the same time lessens the risk of sepsis. Constant irrigation is good from many points of view but I think that there is no need for the use of such a powerful agent as corrosive sublimate during the whole of the operation, after the first washing of the parts I should prefer a hot saline solution as being the less irritating & answering the same purpose. I do not think that there is any need for the preliminary ligature of the vaginal mucous membrane when little bleeding there may be would be easily controlled by the hot irrigating fluid, the same may

he said about the ligatures in front of the vulva between it & the bladder, in which situation there can seldom be any vessel worthy of a ligature, & not only on account of the time involved in applying them but because their presence acts as an irritant to the wounded bladder wall & probably causes the slough which leads to fistula, as happened in two of the otherwise very successful operations I have quoted performed by Dr. Sinclair. In all cases where the vagina is small & narrow I think that the perineum should be incised for I have noticed that if this is not done it is generally very badly bruised or even ruptured by the speculum, while two stitches applied to the inverted incised perineum would be simple repair & cause very little delay in the operation, the bruising otherwise giving much discomfort to the patient afterwards.

The sponges which are placed before & behind the uterus, after the opening have been made into the peritoneal cavity, are of service not only for the sake of preventing escape & of soaking up the haemorrhage & irrigating fluid, but also by keeping the mesentery & intestines out of the way during the injection of the broad ligaments. I think that Dr. Sinclair's early cases are sufficient to show that the drainage tube is not only useless but also objectionable, it fails in its purpose, the urine which is excreted from the injured ureters gravitates to the most dependent part of the pelvis, & at the same time offers an easy path of escape to any germs from the outside. This was particularly well seen in the case of M.E.J. Case X. at the Post mortem I carefully examined the position of the drainage tube in relation to the fluid which had collected in the pelvis & found that it would have been impossible for the fluid to have escaped by its means & I believe that in the first

dressing of Iodoform gauze had been
left alone that the fracture might
have recovered. The Iodoform gauze
acts as a sponge & absorbs each drop
of serum as it is exuded acting in the
same manner as a lamp wick, it also
has another action which is of almost
equal importance namely that it contains
in its substance as it does a very active
antiseptic it offers an almost im-
passable barrier to the ascent of any
obnoxious germs so much so that the
joint packing or drain may be safely
kept in situ at least four or six
days I believe that Dr Sinclair rather
now removes the joint drain upon
the second day by which time the
peritoneal cavity is generally formed to
be cut off from the field of operation.
The dangers of the operation are both
immediate & remote. Of the immediate
dangers shock may be mentioned but
I believe that death from this cause is
rare I have not seen a case mentioned
& I have always formed it to be less

Mean after an abdominal section. The most important accident that might occur is ligature of a ureter but this is not so likely now that the ureters is not inverted & the parts retained out of their ordinary relations. Wounds of the bladder may occur especially when the disease is far advanced or when there has been much accompanying inflammation. Prolapse of mesentery or of intestine does not often occur it is a complication to be guarded against. Actual wounding of the rectum is hardly likely to occur but the pressure of the speculum may give rise to proctitis as it did in the case of J.M. Case XI causing alarming symptoms.
Sepsis is a danger to be carefully guarded against Case XIII being a case in point the symptoms commencing immediately & the patient recovering on the third day she was practically young & strong & in all respects a good case for the radical operation. Of dangers remote we have firstly peritonitis a certain amount of which is I believe necessary for

The closure of the wound but if this necessary amount is exceeded it may easily become general or of any more serious, causing adhesion of the intestines & possible obstruction by their contraction. Sloughing of the bladder wall a few days after the operation may cause fistula & so greatly mar the benefits otherwise derived from a successful operation. The urine should be drawn off at least every six hours so as to keep the parts at rest & the bladder free from over distension. The bowels should be moved on the third or fourth day so as to prevent adhesions The presence of the iodoform dressing on the rectum renders it necessary to introduce a tube for that purpose as well as for the relief of flatus which so often gives distress in all operations on the peritoneum. Cystitis very frequently occurs but as a rule is not a very serious complication but it causes a great deal of discomfort to the patient & should be guarded against by careful

attention to the cleanliness of the catheter & of the external genitals.

Cancer of the uterus is such a dreadful disease that all human surgeons will operate when there is only the smallest hope of a non recurrence & so until the time comes, which can hardly be, there are absolute lines can be drawn between the cases fit & those not fit for operation, statistics of any success cannot be drawn up. The cases I have quoted show this in a marked degree. The surgeon finds it difficult to stay his hand thinking he may be able to cut wide of the disease & not being satisfied as to its extent until it is proved by demonstration on the operating table, it is by this means that his statistics are spoiled & practically useless. So many circumstances combine to deceive the surgeon & human nature, take Dr Donald's second case (XVIII) the local disease was so circumscribed & its eradication

so easy that he was inclined to overlook the fact that the patient's constitution had been poisoned with the disease aided by the accompanying anaemia. I think that that case alone shows the folly of attempting to remove an operation when the cancerous cachexia or poisoning is far advanced. Of course if any of the pelvic glands or uterine ligaments are infected the operation is useless. A very important point is raised by Dr John Williams, as to the direction in which cancer of the cervix spreads, at the last meeting of the Obstetrical society in London, April 20, he states that the disease spreads directly into the parametric tissues & only at a late stage involves the remainder of the uterus, but I must say that of the many cases I have been able to examine the opposite is the case but if it was the case the more radical amputation would be equally useless. It is interesting to compare the discussion which took place in the same society

in 1885 & the discussion of this last month, the opinion is increasing in favour & nothing is more likely to make it advance than a little healthy opposition & criticism, for my own part I am so convinced that it is the only rational mode of dealing with the disease that I should feel it to be my duty to strongly advise it any case of recent origin & uncomplicated by constitutional or other organic mischief such as Phthisis, Bright's disease & such like but I need hardly enumerate such obvious objections to any serious operation. In conclusion I would state my belief that Supravaginal hysterectomy will in the near future be the only radical operation for cancer of the uterus or cervix uteri & that the supravaginal amputation will soon to be performed & only be remembered as an interesting historical chapter in the evolution of modern gynaecological work.

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