Diseases of the Fallopian tubes and their treatment / by Thomas More Madden.

Contributors

Madden, Thomas More, 1838-1902.
Bryant, Thomas, 1828-1914
Royal College of Surgeons of England

Publication/Creation

Dublin : John Falconer, 1892.

Persistent URL

https://wellcomecollection.org/works/ztg7pg3r

Provider

Royal College of Surgeons

License and attribution

Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
https://wellcomecollection.org

DISEASES OF THE FALLOPIAN TUBES,

AND THEIR TREATMENT.

BY

THOMAS MORE MADDEN, M.D., F.R.C.S.Ed.;

Obstetric Physician and Gynæcologist, Mater Misericordiæ Hospital, Dublin;
Physician, Hospital for Sick Children;
Master, National Lying-in Hospital;
Decoré Croix de Bronze "Pour Services rendus a la France pendant la Guerre, 1870-71;"
Member, Royal College of Physicians, Ireland, and Surgeons, England;
Examiner, Conjoint Board, Royal College of Surgeons and Apothecaries' Hall, Ireland;
Socio Coriespondente, Con Medaglio d'Oro, del Associazione dei Benemerite Italiani;
Ex-President, Obstetric Sections, British Medical Association and Royal Academy of Medicine, Ireland;
Formerly Vice-President, British Gynæcological Society;
Hon. Member, Texas State Medical Society;
M.D. *Honoris Causâ*, Texas State Medical College, Galveston;
Corresponding Member, Gynæcological Society of Boston, &c.

DUBLIN:
JOHN FALCONER, 53 UPPER SACKVILLE-STREET.

1892.

DISEASES OF THE FALLOPIAN TUBES

AND THEIR TREATMENT.

THE accurate differential diagnosis and successful or radical treatment of Fallopian tube diseases have only become generally obtainable within a recent period; and for that advance we are largely indebted to the teaching and practice of Mr. Lawson Tait and some other leaders of the modern school of abdominal surgery. Nevertheless, it may not be superfluous to remind you of the somewhat ignored fact that the disorders of the uterine appendages were by no means unfamiliar to many of the older writers, by whom, and more especially by Astruc,[a] of Paris, in 1761, and by Kruger,[b] of Gottingen, in 1782, their pathology was fully discussed; whilst by others very remarkable instances of what we now term pyo-salpinx, and hydro-salpinx, as well as other tubal troubles, have been narrated. Thus Portal[c] quotes, *inter alia*, a case from De Haen of "abscess in the left Fallopian tube which contained eighteen pints of pus;" and another from Munieks of "an enormous Fallopian cystic tumour, the contents of which were estimated at upwards of a hundred gallons"! He also cites from Harden the instance of "a woman in one of whose Fallopian tubes was found encysted a hundred and forty pounds of an aqueous fluid"! These or other cases of Fallopian disease were also referred to by Bailey,[d] Hooper,[e] and other writers of the first two decades of this century, and above all, a little later, by Dr. Davis,[f] by whom the symptoms and pathology of diseases of the oviducts as then understood were distinctly described in 1835.

[a] Astruc. Traité des Maladies des Femmes. Paris. 1761.
[b] Kruger. Pathologia Ovariorum Muliebrum. Gott. 1782.
[c] Portal. Cours de Anatomie Médicale. Tome V., p. 540.
[d] Bailey. Diseases of the Uterus, &c. P. 504.
[e] Hooper. Morbid Anatomy of the Human Uterus. P. 3.
[f] Davis. Obstetric Medicine and Diseases of Womb. Vol. II., p. 760. 1835.

From that time may be dated the general recognition of the fact that the Fallopian tubes, being so intimately connected as they are structurally and functionally with the uterus, must necessarily therefore be liable to inflammatory diseases similar to those which affect that organ, however modified these may be in their symptoms and consequence by the special organisation and relations of the oviducts.

The diseases which may be thus transmitted to the Fallopian tube not only from its uterine orifice but also through its free peritoneal extremity, or which may originate within its structure, are, firstly, inflammation, or salpingitis, and its consequences—viz., pyo- and hydro-salpinx—of which probably the most common causes are gonorrhœal infection and puerperal sepsis. Besides these the oviduct may, moreover, be the seat of encysted, fibro-muscular, and malignant tumours.

Acute Salpingitis.—Acute inflammation of the Fallopian tubes may be here very briefly disposed of, inasmuch as salpingitis is seldom brought under gynæcological notice until the disease has reached the chronic stage. It is most frequently observed attending the puerperal state as a complication or consequence of septicæmia, when its occurrence is indicated by deep-seated, throbbing pain, extending from the iliac region into the groins and thighs, together with local tumefaction and tenderness, recognisable by conjoint recto-abdominal or bimanual examination over the course of the broad ligaments, in which the tortuous outlines of the hyperæmic and enlarged oviducts may be thus detected. The most common result of acute salpingitis is the chronic form of the disease. It may, however, also terminate in resolution or cure, as well as in the occlusion or obliteration of the ducts in any part of their course by the cohesion of their walls from plastic inflammatory exudations. As to the treatment of such cases, I know of nothing very reliable that can be recommended beyond allaying pain by opiates and administering quinine in combination with iodide of potassium or bichloride of mercury. Hot water vaginal, and rectal, irrigation and external stuping are obviously indicated, and are most likely to prove successful in acute catarrhal salpingitis, whilst it is difficult to see what possible benefit can be produced by counter-irritation by blisters or strong mercurial ointment over the inguinal region, which though still occasionally employed in such cases, are more likely to add to the discomfort of the patient than to cure the disease.

Chronic Salpingitis may affect either one or both tubes; more generally both are implicated, although in different degrees. Its extrinsic causes may be either gonorrhœal, puerperal, or catarrhal, whilst occasionally it may arise from local causes, such as tubercular and cancerous deposits in the tubes. Moreover, as might be expected, salpingitis and its consequences are more frequently met with during the earlier period of marital life, and in those in whom the utero-ovarian or sexual functions have been most exercised, than in patients more advanced in years and of non-erotic temperament. Thus Dr. Bland Sutton, who in his pathological investigations has had an extensive opportunity of examining the bodies of a large number of women of ill-fame, in most of these instances discovered evidences of hyo- or pyo-salpinx, or in some cases found one or both Fallopian tubes represented by an impervious cord and the ovaries atrophied and unrecognisable. This induces him to believe that the frequency of tubal disease between the age of twenty and thirty-five years and its relative rarity after the fortieth year is to be accounted for by the fact that, if the individual survive the dangers incident to an inflamed and distended tube, the diseased parts atrophy.

Symptoms of Chronic Salpingitis.—The general symptoms of chronic salpingitis, before the disease has eventuated in pyo- or hydro-salpinx, are scarcely distinguishable from those of the generally co-existing oöphoritis, and, later on, its effects and evidences are symptomatically almost identical with those of pelvic cellulitis or perimetritis, and in former days were commonly confounded with that disease. Of these symptoms of chronic tubal disease the most important are the recurrence of otherwise unaccounted for, and generally unrelievable by ordinary treatment, attacks of menorrhagia attended with dysmenorrhœa, or impeded through protracted or excessive menstruation. In such cases the patient further complains of a characteristic deep-seated, intra-pelvic pain which—in some instances from the first, and in almost all cases during the progress of the disease—sooner or later becomes acute or lancinating, shooting out into the sacral and inguinal regions, and extending down the thighs. At the same time may be also noted evidences of constitutional febrile disturbance and pyogenic rigors, and in some cases intra-menstrual hæmorrhages or aqueous discharges from the uterus, together with local tumefaction and tenderness in the course of the oviduct discoverable on examination per rectum.

The Pathology of Pyo- and Hydro-Salpinx has recently been fully investigated by a distinguished pathologist, Dr. Bland Sutton, and I cannot do better in this connection than place before you the following abstract of his observations on this subject, which may be found *in extenso* in the *Lancet* of December 6, last year:—

"*Pyo-Salpinx.*—In severe cases of salpingitis after occlusion of the abdominal ostium, accompanied, as is usual, with stricture of the uterine end of the tube," the pus "is as securely locked up in the tube as it would be in a deep-seated abscess, and it follows the course of an abscess. The walls of the tube, stretched by the accumulating pus, gradually thin, and the inflamed tube becomes adherent to surrounding structures—ovary, uterus, rectum, intestine or broad ligament. The wall of the tube continues to thin until, on some slight exertion, it bursts. If the pus be discharged into the peritoneal cavity, it establishes rapidly fatal infective peritonitis. Right pyo-salpinx is very prone to open into the rectum. When a pyo-salpinx lies in contact with bowel, the pus it contains becomes abominably fœtid, due to osmosis of the intestinal gases. The relation of pyo-salpinx to the rectum must be studied in connection with tubo-ovarian abscess. The first effect of salpingitis upon the ovary is to cause thickening of its capsule, and if lymph is effused upon its surface this may organise and extensive perimetritic adhesions result. The effects of this thickening of the capsule are twofold. At first it prevents the rupture of ripe ovarian follicles, and the tension gives rise to considerable disturbance and causes pain; and as the enlarged follicles cannot discharge their contents, it naturally follows that on section an ovary which has long been the seat of peri-oöphoritis will be found largely converted into cystic spaces, and two or more may become confluent and form a cyst the size of a walnut. As such a cyst enlarges and makes its way by absorption to the surface, it not infrequently comes into relation with and adheres to the dilated pus-containing ampulla of the corresponding tube, which has been brought in contact with it through the restraining influence of the tubo-ovarian ligament. Not infrequently absorption takes place, and the dilated ampulla of the tube will communicate with an enlarged follicle or cyst in the ovary, and thus give rise to a tubo-ovarian abscess, which may be discharged by way of the rectum at irregular intervals."

When the infective qualities of pus are not great a pyo-salpinx gives rise to few symptoms. It is this form of pyo-salpinx that,

becoming gradually dilated with fluid, is eventually converted into a hydrosalpinx, which, as a rule, may be regarded as merely a late stage of pyo-salpinx.

Many milder attacks, however, may be described as "catarrh of the tube," and like a nasal or gastric catarrh subside and leave no trace. If the inflammation is sufficiently intense to seal the ostium permanent damage results, and if, as is so commonly the case, both tubes are affected, they remain throughout life functionless, and often a source of grave danger. In cases of salpingitis sufficiently severe to occlude the ostium the tube is, after the subsidence of the inflammation, in the condition of a blocked ureter; there is no escape for the fluid which is excreted by the glands in its walls, or for the fluid which passively exudes into its cavity. It consequently forms a cyst by retention. The fluid is either colourless or greenish owing to the presence of cholesterin.

In some instances the fluid, as before stated, may escape at irregular intervals through the uterus, constituting what has been described as "hydrops tubæ profluosis," and which is accounted for by Dr. Sutton as resulting from the occurrence of Fallopian fistula in such cases. In other instances, again, the exudation may take place through the abdominal ostium of the tube, possibly giving rise to fatal peritonitis, or in non-septic cases to "hydroperitoneum," which has been defined by Mr. Alban Doran as a collection of fluid in the peritoneal cavity that cannot be referred to any tangible organic disease, except chronic salpingitis of a mild type with an unobstructed tube.

Before referring to the treatment of these conditions, I shall in the first place briefly recapitulate the excellent notes taken by my clinical resident, Mr. G. Whyte, of a case of chronic salpingitis, which may serve to exemplify the ordinary course and results of that disease:—

Case.—A. O'N., aged twenty-four, unmarried, an anæmic-looking draper's assistant, admitted October 17th, suffering from menorrhagia for two years previously. The changes, she stated, lasted from six to eight days, and were accompanied by much suffering. She also complained of almost contnual pain in left groin and backache, together with a bearing-down sensaton.

On vaginal examinaion the position of the uterus proved normal, and nothing beyond some slight endo-cervicitis being apparent except an unusual flattening of the roof of the vaginal posterior *cul-de-sac*. An examination by the retum was made, on which distinct fulness and

fluctuation was discovered in Fallopian tube, which was much enlarged. The aspirator was employed, and a long needle was passed through vaginal *cul-de-sac* and guided by finger *in situ* to most prominent part of tumefaction, at which it was introduced, and on turning the tap about six ounces of turbid puro-serous fluid was evacuated. No subsequent dressing was employed; the vagina and uterus both daily irrigated with hot water. She was put on iodide of potassium and bark mixture. Rapidly convalesced, and was discharged on December 9th.

Treatment.—In the treatment of chronic salpingitis and the resulting pyo- or hydro-salpinx, it appears to be not unfrequently lost sight of, that in these, as in all other cases, the gynæcologist should set before him not only the removal of disease, but also the restoration of the functional and structural integrity of the affected organ, as far as these objects can possibly be combined and accomplished; and that only where the latter is impracticable, should he be content with the former. With this view several methods of dealing with the cases now under consideration have been suggested—viz., firstly, the removal of the contents, whether purulent or serous, of the distended tube by aspiration, as recommended by Dr. Routh, as well as some years ago by myself in several papers read before meetings of the Royal Academy of Medicine in Ireland, the Brighton meeting of the British Medical Association, and at the Washington meeting of the International Medical Congress, in which I also discussed the expediency and showed the possibility of catherisation of the Fallopian tubes in certain exceptional instances. Secondly, by free incision per vaginam, and subsequent washing out of the emptied tubes, as advocated by Dr. Sinclair. Thirdly, curetting the endometrium around the uterine ostium of the tube, and Emmet's operation. Fourthly, employment of electricity by the method of Apostoli. Fifthly, by what may be termed conservative laparotomy—*i.e.*, abdominal section with the view either of aspiration of the distended ducts, or, as advocated by Mr. Alban Doran in some instances, for the purpose of breaking down adhesions and "freeing the diseased appendages." Sixthly, may be here mentioned the resection of the tube by salpingotomy or Skutsche's operation. Seventhly and lastly, in this connection is massage as employed by Brandt in such cases

I shall not here waste time by referring in extent to any of these procedures, save those that I have myself proved the practical utility of. This is not the case with regard to salpingotomy, concerning which, as well as other "fancy operations" that may more safely be

demonstrated on a lecturer's diagrams than in a patient's body, I would re-echo Dr. Goodell's criticism—"The diseased parts cannot be handled in abdominal section without great risk. The tube is often tensely distended, and adhesion to neighbouring structures are usually intimate. Hence the tube may carefully be ruptured, intestines torn, and circumscribed collections of pus diffused." As to massage, even if harmless, it would be objectionable for the general reasons I have mentioned when referring to this subject in a previous lecture. But in cases such as those under consideration, even that negative merit can hardly, I think, be attached to a procedure like that by which, according to the writer just cited, one of its advocates—viz., Brandt—is credited with venturing to attempt the emptying of a distended tube into the uterus by "rolling it gently between the fingers of both hands," a manœuvre which, it is admitted, often causes "an escape of secretion into the peritoneal cavity, which readily gives rise to symptoms of peritonitis!"

Turning from these fond fancies of transcendental scientists or enthusiastic fadists to the sober realities of practical gynæcology, we may now consider the rational treatment of pyo- and hydro-salpinx, in regard to which there appears to me no reason to depart from the traditionally recognised first principles of surgery, by an indiscriminate resort, in the first instance at least, to such heroic operative measures as the complete extirpation of the uterine appendages. If the mammary gland, for example, becomes the seat of a purulent collection, or if, as Sir Spencer Wells suggests, the tumica vaginalis testis is the location of a hydrocele, would it not be more advisable to open the abscess or to tap the hydrocele than to amputate the breast or to remove the affected testicle? And must we then necessarily adopt an entirely different course as a matter of general practice in dealing with analogous conditions in other no less important organs?

Acting on these principles, therefore, for several years past, I have, in the first instance at least, treated a considerable number of cases of pyo-and hydro-salpinx by aspiration and other conservative measures. The successful results thus obtainable in many, though by no means in all, instances of this kind have been proved in my wards in the Mater Misericordiæ Hospital. The majority of cases of this kind were there treated by that method, to which I have elsewhere referred, before its advantages were recognised. This treatment, even if not as certain in its radical curative results as salpingotomy, is certainly quite as successful in that class of cases

to which its employment should be restricted, and at least contrasts favourably as far as facility of performance and safety from danger with the latter operation which in other cases or after its failure may become no less expedient. Hence I shall venture for an instant to dwell on the details of the less serious method, which, as I believe, will in not a few instances be found to afford satisfactory results whenever tubal collections are accessible per vaginam. In the first place, to permit the necessary manipulation, the patient should be put under some anæsthetic and placed in the ordinary left lateral gynæcological position. Then the operator introduces the index and first fingers of his left hand through the sphincter ani upwards and forwards along the outlines of the posterior uterine wall, the fundus being pressed down by his assistant's hand over the hypogastrium. In this way the tubes and ovaries can be readily palpated, and if there be any inflammatory or cystic enlargement of the former it may be distinctly recognised as a tortuous, elongated, or sausage-shaped or rounded fluctuating tumour, extending, as Dr. Wm. Duncan says, "from the side of the uterus outwards to the broad ligament and backwards into Douglas's fossa." Having thus ascertained the position of the pyo- or hydro-salpinx, the next step is to carefully introduce per vaginam on the point of the right index finger a long fine needle affixed to the aspirator up to the roof of the posterior vaginal *cul-de-sac*, through which it is to be passed into the retro-vaginal fossa, and thence guided by the operator's left index from the rectum up to the most prominent presenting part of the tubal swelling, into which it is to be plunged. The tap of the aspirator is then to be turned, so as to give exit to the contents of the dilated tube, the expulsion of which may be assisted by the steady pressure of the assistant's hand from about the hypogastrium down into the pelvic cavity, and continued until the tube is completely evacuated. After this the vagina should be rendered aseptic by insufflation with iodoform, and then no further local treatment beyond hot water irrigation will generally be required, unless the tube should, as sometimes happens, again fill, though probably to a lesser extent, when the same procedure may be again and again, if necessary, repeated until the oviduct has become reduced to its normal size.

Curetting Fundal Orifice of Tubes; Treatment by Electricity.—Apart from malignant and other degenerative changes, the most common immediate cause of cystic accumulations in cases of chronic salpingitis is mechanical obstruction of the uterine orifice of the

oviduct, due either to chronic follicular endometritis, flexion, or, in some instances, supra-involution of the uterus. Under such circumstances the tubal obstruction is most likely to be relieved by dilatation followed by curetting of the diseased proliferating endometrium in the first instance, or by the rectification of the flexion in the second, and by faradisation in the last-named cases. The faradic current has, moreover, not only in these, but also in other forms of chronic salpingo-oöphoritis, been in some instances successfully employed by Dr. Apostoli, of Paris, who generally employs in such cases the faradic current of tension applied in moderate doses and for only a few minutes at a time, for which he claims the most remarkable curative results in such cases. Another recent authority on this subject—Dr. Milne Edwards, of Edinburgh, does not believe, however, that the galvanic current is suited to cases where there is definite organic change in the ovaries, but considers that here faradism may possibly be of service.

Removal of Uterine Appendages.—In those graver and, as I hope may yet be found by others of higher authority than myself, somewhat more exceptional cases than is generally supposed, in which, from the extent of Fallopian disease, or from the implication in its course of adjoining structures, the urgency of the symptoms attending its progress or other causes, it becomes impossible to deal satisfactorily or safely with such cases by the methods already referred to, and in which more active surgical intervention is obviously indicated, there then only remains for our adoption the complete removal of the uterine appendages.

That operation has, however, now come into vogue under other circumstances than these, being supported by a large number of modern gynæcologists, as not only the most efficient, but also, in the cases in which it is required, the safest method of dealing with the tubal diseases referred to; and hence the procedure which should be generally adopted in such cases. This doctrine I cannot, myself, altogether unreservedly accept, believing, as I do, that in some instances the results of salpingitis are curable without any active treatment, and that in other cases they are amenable to the minor measures I have described. Nevertheless, in this hospital and elsewhere I have met with cases in which the only apparent alternatives were either the speedy death of the patient from Fallopian-tube disease or else the complete removal of the affected appendages, by what is generally known as "Tait's operation," after the name of the distinguished surgeon by whom it was intro-

duced, and has been most successfully carried out in this country. In the following observations I shall therefore very briefly describe that operation, or, at least, that method of performing it which you have here seen practised, premising that, regarding, as I still do, the ovaries and tubes as both essential factors in the menstrual function, it follows that when the latter are removed, with salpingotomy should also be combined öophorectomy, to obviate the possible consequences of an abortive or abnormally-accomplished process of ovulation. Nearly all the preliminary successive steps of this procedure being identical with those of ovariotomy, I shall merely allude to those points in which these operations may be contrasted. The first and most obvious of these is the smaller size of the abdominal wound required for removal of the appendages. This incision should only be just sufficient to allow the introduction of the two first fingers of the operator's left hand, which should be passed down to the fundus uteri, by the position of which he will be readily guided to the contiguous tubes and to the ovaries. In such cases the often widely-distended oviduct must be most tenderly handled to avoid extravasation into the peritoneal cavity of a pyo- or hydro-salpinx, which may occasionally be prevented by aspiration of the diseased tube before any attempt to draw it out through the abdominal wound, as must be the next step in this operation when not rendered impossible by extensive inflammatory adhesions. Having thus drawn out, as far as can be safely done, the affected tube and ovary, so as to form a kind of pedicle from the broad ligament, through the centre of which, carefully avoiding injury to blood-vessels as far as possible in so doing, a blunt-pointed needle carrying a double ligature of stout silk is to be passed. This ligature may next be secured by an ordinary "reef knot," which I have found sufficiently reliable and easier to make than it would be for me to acquire the probably still better "Staffordshire knot," the use of which has been thus described by Dr. Macnaughton Jones:—"A loop of double ligature is passed through the centre of the broad ligament, avoiding the vessels. The loop is then turned back so as to include both the ovary and tubes in the two loops thus formed. One free end is then passed through the returned loop; both ends are now drawn together and then cut off." Whatever ligature be employed it should secure the pedicle, from which the ovary and oviduct are next to be separated by a blunt scissors curved on the flat, a little above the point of ligation, which may be then dropped back into the

peritoneal cavity. A similar procedure may then be adopted with regard to the remaining ovary and tube, after which the abdominal cavity may be washed out with warm water, the wound closed, and the case treated on the same general principles as an ordinary ovariotomy.

This operation, although under ordinary circumstances feasible enough to any surgeon, is occasionally, however, one that might puzzle the most dexterous specialist to carry into effect. The difficulty of removing a Fallopian tube that may possibly be distended to the point of bursting by a pyo-salpinx, without risk in so doing of rupturing the thin tensely-stretched walls of the purulent sac into the peritoneal cavity, is obvious. But where, moreover, as occasionally happens in such cases, the ovaries and tubes are matted together, and to the ligaments, uterus, and other adjoining structures in one inextricable mass by inflammatory exudations and adhesions, that difficulty may be converted into an impossibility in some instances. I have myself had occasion to remove the uterine appendages in several cases, and, as I believe, have generally obtained results neither better nor worse than the average of other ordinary gynæcologists. But, at the same time, I think it not improbable that such other practitioners as well as myself may have sometimes regretted that they had not either operated earlier or that they operated at all in those exceptionally unpromising cases to which I have just referred.

The immediately successful results now obtained from the removal of the uterine appendages in the majority of cases, and the very small mortality consequent on its performance in suitable cases in the hands of skilled specialists, has been proved beyond any possibility of question by the statistics of Mr. Tait's vast series of cases, as well as by those of Dr. Bantock and many other eminent surgeons. Of the ultimate curative results of removal of the uterine adnexa, however, a less hopeful view is taken by some authorities whose opinions on this subject are no less entitled to consideration. Thus Mr. Alban Doran observes:—"As a rule, oöphorectomy for chronic disease of the appendages is followed by speedy convalescence. Unfortunately, a permanent cure is not so frequent. Mental symptoms occasionally follow double oöphorectomy. The cases where the stump suppurates are particularly unsatisfactory. Fistulous tracts open, close, and re-open in the abdominal wound for months, discharging thin pus. Such cases find their way to the consulting rooms of others, or to other hospitals than the institution where the

operation was performed. The operator hears no more of them, and he or the hospital registrar records them in perfect good faith as 'cures.' A larger minority suffer from a continuance of the pains which preceded the operation, probably on account of intestinal adhesions, or through irremovable inflammatory products which press on nerves. The ligatures certainly set up trouble in some cases."[a]

Somewhat similar views have been previously expressed by other writers. Thus Dr. H. C. Coe, in the Proceedings of the New York Academy of Medicine, observed:—"There are not a few women now attending the various clinics in New York who have had their ovaries and tubes removed, and yet who complain of precisely the same pain as before; in fact, I can recall cases in which, although the menstrual disturbance is wanting, the pain is more severe than it was before."

I, therefore, think that, without in any way questioning the necessity for these operations in many instances, or the success and small mortality which has attended their performance in the hands of a few distinguished surgeons, the great body of medical practitioners who occasionally must meet and deal with cases of Fallopian tube disease, should be very slow to adopt operations the success of which can only be assured by exceptional skill, and that even where the circumstances of the case preclude the possibility of transferring the responsibility to those possessing that capacity, they should, before attempting to imitate their practice, at least fairly and fully try the less heroic but yet often successful methods of treatment to which I have already alluded. I have recently had clinical reason to know that the repetition of this recommendation is not superfluous at the present time, having in this hospital within the past couple of sessions met with the effects of its disregard.

A few years ago I brought the increasing frequency in general surgical practice of operations for the removal of the uterine appendages, and by no means only when rendered necessary by Fallopian disease, or for uterine myoma, under consideration in papers read before the Obstetric Section of the British Medical Association and elsewhere, to which I have already referred. And as the general accuracy of my opinions on this subject has been confirmed by my more recent experience, I may here recapitulate the views I then expressed, and still hold.

I fully recognise the fact that the first duty of the surgeon is

[a] Alban Doran, F.R.C.S., "On Treatment of Chronic Diseases of Uterine Appendages" in the Lancet, January 17, 1891.

to save his patient's life; and, therefore, if in a case of Fallopian tube, or other, disease, this can only be done by immediate removal of the uterine appendages, that this operation should then be at once resorted to. But under any other circumstances it should never be lost sight of that the uterine appendages are as essential to reproductive capacity in women, as are the testes in men, and that by their complete removal the patient is practically unsexed or incapacitated for the chief function and primary object of woman's married life. Nor does it seem to me ever justifiable to perform such operations without the patient's full concurrence and knowledge of the consequences—a rule the propriety of which is obvious, and is now generally recognised and acted on. At the same time, however, it appears to me that the removal of the ovaries and Fallopian tubes is even yet occasionally somewhat too readily resorted to in non-organic disease as a possible means of benefiting neurotic and hysterical symptoms. It may, therefore, be well to repeat that other operations and methods of treatment have ere this been for a time as generally accepted; and then, having perhaps been carried beyond their judicious application, have fallen into desuetude. We have, therefore, no guarantee in the present frequency of resort to the removal of the uterine appendages that the same may not in course of time happen also with regard to these operations which, unquestionably valuable and successful as they have proved in the hands of some eminent surgeons, in cases of absolute necessity should, in my humble judgment, never be lightly regarded as measures of election.

The question of election or necessity I regard as the cardinal point to be decided in considering the expediency of removing the uterine adnexa in the treatment of Fallopian tube disease. In many instances, unquestionably, as I have already said, that course becomes an unavoidable necessity, and is then the obvious duty of the surgeon. It should never be forgotten, however, that in probably a no less large number of cases, tubal diseases may also be successfully treated by some of these the much less heroic, but effectual remedial and conservative, measures to which I have referred.