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THE USE OF MORPHINE AND OTHER STRONG SEDATIVES IN GYNÆCOLOGICAL PRACTICE.*

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The general practitioner and the specialist are directly responsible in many instances for the continuous use of morphine as the means of relieving pain in the treatment of gynæcological cases. The general practitioner frequently meets with cases with ill-defined pelvic pains, cases of intestinal colic or cases with distinct ovarian pains; and these seem, without question, to his mind, to call for morphine. This he administers repeatedly in the acute attacks, oftener by hypodermic injections. The relief thus afforded is, of course, only temporary, and in each subsequent attack the patient will not rest satisfied unless the same treatment is carried out.

Such practice is, I believe, becoming more and more widespread, and it is popular for the reason that it affords the greatest amount of immediate comfort to the patient and to the doctor.

Such methods are not only resorted to by the general practitioner, but by many gynæcologists, who in this way treat ill-defined pelvic troubles associated with pain. Unless, too, we can afford the patient immediate relief, and keep her comfortable and in a happy frame of mind, she frequently will forsake us for those who will prescribe the desired remedy.

Under such circumstances the "morphia habit" is easily contracted, not only in cases where an idiosyncrasy to the drug already exists, but where no such tendency has been present. It is particularly in the cases of acute suffering ac-

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companied with marked nervous symptoms that the patient readily becomes a morphia habitué. Under this class we place cases of minor pelvic lesions; particularly in those women who have slight disturbances of the normal menstrual flow, producing dysmenorrhœa. If these patients are treated according to their symptoms alone, they will seem to demand immediate relief at all hazards. The nervous symptoms predominating in these cases as a rule, ordinary measures adopted are unsuccessful, except by agency of morphine or some efficient substitute. These cases, in a short time, become thoroughly dependent upon the drug and are rarely entirely relieved or comfortable unless under its influence. Also where displacements of the uterus exist, where the most prominent and constant symptom is backache, nothing affords such instantaneous relief as morphine. Such cases soon become completely addicted to its use. The ultimate outlook under such treatment is practically hopeless. The nervous, worn-out woman, suffering pain at her menstrual period, sufficient to completely overthrow her nervous command, naturally seeks the sedative to rid her of her discomfort, and certainly cannot be censured for so doing. If morphine is administered under these circumstances, its seductive effects soon form the sheet-anchor of her existence, and in her nervous condition the habit takes possession of her very soul.

Analysis of cases.—The practice of using morphia, then, for simple pains and neuralgias of different varieties, cannot be too strongly condemned. In many instances the patient applies directly to the drug shop for morphine or for some preparation containing it or some of its constituents. The druggist, too often irresponsible, thus dispenses these drugs to whomsoever may desire it, and as he is in utter ignorance as to the necessity for the drug, neither can he nor the patient appreciate the dangers which are incurred. As these preparations afford the most relief, without further thought they take it for granted that it is precisely what their condition requires, and they then resort to its use on the slightest provocation, without ever asking a physician's advice. Such patients, long before they are aware of it, learn to depend entirely upon it for relief and in this way quite unconsciously fall under its pernicious influence; so that in a brief time they require the drug independently of the primary condition for which they began its use. The physician who is called to attend this class of patients is driven to his wit's end to know what to prescribe, and unfortunately he resorts too quickly, in the vast majority of cases, to this dangerous method of treatment. If a patient becomes a victim of the habit in this manner, the attendant should be held personally responsible, and the legal restriction provided should be enforced to prevent the drug from being sold by any druggist, without a physician's prescription.

The administration of morphine after operation is also too much of a routine treatment with *surgeons.* To this practice the *habit* can unquestionably be traced in many patients. It is the practice of these operators to keep their patients under the influence of morphine for two or three days subsequent to operations. Unless physicians are extremely careful they easily fall into the way of prescribing morphine under these conditions, and the patient will be in great danger of becoming addicted to its use. It is occasionally called for, but in the vast majority of cases I feel sure that patients do not require any sedative at all after operations. We should, to this end, enlist the moral support of the patient herself, explaining that if she endures the suffering for a short time, she will make a much better recovery. The effect of using morphine after operations is not only that after a short time the patient feels the necessity of its repeated use, but she is much more difficult to manage, becoming restless and fretful, com-

plaining loudly of the simplest suffering, and altogether her mental condition is unbalanced.

In the care that I have had of over 700 cœliotomies, (abdominal sections) and a large number of plastic cases, morphine has been required in but few instances. Where it was impossible to do without it, at the outside but one or two doses have been given; it can thus, perhaps, in a small percentage of cases, be safely administered; but I have observed that when only one hypodermic, even of 1/8 of a grain, has been given, in some instances the patient would be thoroughly demoralized for two or three days; as previously stated, it not infrequently takes as long as this for its depressing effects to entirely disappear.

I have met with cases that have acquired the morphia habit after gynæcological operation, coming from the clinics of eminent gynæcologists. In some instances they not only acquired the morphia habit, but also, what so frequently happens, they were obliged to resort to stimulants, when they were not under the influence of morphine. I have seen such a condition utterly destroy a patient's life. Many such cases undoubtedly exist to-day, solely as a consequence of what I believe to be the careless and unnecessary administration of morphine after operations. It is the iron-bound rule in the gynæcological department of the Johns Hopkins Hospital, in post-operative cases, to give it only in case of dire necessity. Long series of serious cœliotomies and plastic cases there convalesce thoroughly, satisfactorily and comfortably, without the administration of any morphine or other sedative.

In what cases is it permissible to use morphine?

A proper but limited use of morphine is justifiable in cases of inflammatory pelvic disease. Further, in cases impossible of relief by operative measures, as cancer of the uterus involving the broad ligaments or neighboring viscera. In order to relieve the great suffering that is present at times, it is necessary to use morphine, but even in these instances it should be relied upon only as a last expedient, as many cases are rendered comfortable and practically free from pain by the use of local treatment; such as cleansing the parts by hot, medicated douches, the use of the cautery or curette, singly or in combination. Also in cases of large adherent myomas where the structures are so universally bound down that we have nothing else but palliative measures to depend upon.

Finally, in cases of pelvic inflammatory disease preparatory to operative measures: In the treatment of these cases it is, however, of the greatest importance to examine the patient complaining of obscure pelvic lesions, under anæsthesia; this is the only absolute means of ascertaining the condition of the pelvic contents. Too much importance, I feel sure, cannot be laid upon this as a routine practice. We are thus at once in a position to carry out our treatment, having ascertained the local condition of the parts by a careful process of exclusion. For instance, if we have a patient complaining of indefinite pelvic pains who also presents a history that would seem to indicate, positively, inflammatory disease, without, however, the examination under anæsthesia, we are not able to say positively what is the condition of the pelvic contents. Therefore, if in a given case we find marked structural changes or adherent masses with a suggestive clinical history, we can safely, perhaps, resort to small quantities of morphine preparatory only to near operative measures. This practice, however, should be a guarded one, and we must use only sufficient of the sedative to act merely as a temporary agent, or, in other words, until the operation can be performed. Only under these circumstances do I believe it is ever judicious to employ morphine for pelvic inflammatory conditions.

Many cases of established morphine habit I have seen successfully cured by operative measures. This method of treatment originated with Dr. Kelly, who carried it out successfully in numerous instances in patients who, as a rule, had passed through the hands of several gynæcologists who operated for various symptomatic abdominal inflammatory diseases. These patients were prepared for cœliotomy and carefully examined, bimanually, for adhesions. The abdomen was opened, and a search made and any adhesions released; then the abdomen was closed and morphine in any form was absolutely forbidden. I believe this to be a method worthy of trial in these gynæcological morphia cases that are otherwise hopeless.

In conclusion I make the following suggestions :—

1. That general practitioners, but more particularly specialists, should carefully scrutinize every prescription they write containing morphine, and that under no circumstances should its enewal be allowed unless under their personal supervision.

2. The patient hould never be allowed the use of a hypodermic syringe.

3. The druggist should be prevented from dispensing morphine without a prescription.

4. Whan morphine is prescribed, the patient should never be informed of the character of the drug.

These remarks apply to all analgesics, and sleep producers, particularly chloral, chlorodyne, sulphonal, etc.

As substitutes for morphine, I would advise, where practicable, electricity; internally, in guarded doses, gelsemium, phenacetin; and as local applications, the cautery, oil of peppermint and oil of wintergreen.