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EARLY DIAGNOSIS ESSENTIAL FOR THE CURE OF UTERINE CANCER.

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IN THE MEDICAL NEWS of December 5, 1891, I published an article on the radical treatment of uterine carcinoma. In it I contended that, for this deadly disease, the only trustworthy operation is the removal of the womb, and that, both in its immediate and in its remote results, it is an extremely satisfactory operation. Statistics were adduced to show the very low rate of mortality from this operation when performed in appropriate cases *per vaginam*, and not through an abdominal incision. These statistics also warranted the assertion that the remote or permanent success of this operation far exceeded that of all operations undertaken for carcinomata in all other parts of the body, the number of cures being surprisingly large. This success was attributed to the anatomical fact that the lips, breast, penis, and rectum—the favorite sites of cancer—are integral parts and parcels of the body; while the womb is to the body only an appendage. It is an organ not integral, but complemental—one which, as it were, is merely hung in the pelvis, and that by ligamentous bands of a mongrel tissue not homologous with that of the womb. The technique of the various

operations for vaginal hysterectomy was also described, but the preference was given to that by the progressive catgut ligature.

A year's additional experience with this radical treatment of carcinoma of the uterus, so far from changing or even modifying the foregoing views, has served still further to confirm them, and I unhesitatingly urge this operation in every suitable case. But what is a suitable case of uterine cancer? It is, firstly, one in which the womb is removable; and, secondly, one in which an operation promises well, both in its immediate and in its remote results. A suitable case, therefore, is one in which the womb is not fixed, the vagina is free from all carcinomatous nodules, and the broad ligaments show no signs of infiltration. In other words, a suitable case is one in which the neoplasm is limited wholly to the womb. In such a typical case the operation is easy, safe, and curative.

Unfortunately, however, in the great proportion of cases that present themselves for the first time to the surgeon, the disease has become too far advanced. The growth has probably crept up the cervix and, penetrating its substance, has invaded the bladder or the vagina. It has travelled along the broad ligaments and deposited its germs outside of the womb. By this time the womb will be more or less fixed, and the bladder and the vagina firmly sealed to it. The surgeon, therefore, has either to reject the case or he has to perform a dangerous operation, which can be only palliative, and not curative. The gist, then, of a successful treatment lies in an early recognition of the cancer.

In a very large proportion of the cases the disease begins in the vaginal portion of the cervix. It does so because this part of the womb bears the brunt of the injuries sustained in coition and in parturition. The cancerous nodule, or ulcer, starts usually in the notch of a torn cervix, and it is, therefore, most commonly found in women who have borne children. I have not, indeed, to my recollection ever seen but a single case of cervical cancer in a virgin, and not more than three cases in sterile women. One of these three cases, although apparently an exception to the rule, singularly enough confirmed it. The lady had a submucous fibroid, which was slowly emerging from its uterine bed. After suffering much pain and losing much blood for several months she decided to call me in. I found the os uteri dilated to the size of a silver dollar, and crowning the protruding fibroid like a fetal head. The tumor was seized, wrenched from its bed, and delivered, but not without difficulty, as it was larger than the os uteri. A few months later carcinoma of the cervix set in.

The ordinary symptoms of carcinoma in the usual order of their appearance are: Pelvic pain, ichorous leucorrhea, hemorrhages, fetid discharges, and general cachexia. But, while these symptoms are characteristic, some of them may be absent, or their sequence may be variable. Thus, pain may not be present, or the malignant ulcer may first reveal itself by a hemorrhage; sometimes, indeed, by a general cachexia, which by rights should be the final symptom.

The symptoms on which the majority of physi-

cians lay too much stress, and on which the laity wholly rely, are lancinating pains and fetid discharges. Now, very unfortunately for an early diagnosis, these symptoms rarely assert themselves until the disease has advanced too far for its radical treatment. The symptom of pain, which is so widely deemed essential to malignancy, is a very delusive one for the physician to lean upon. We all know how insensible the cervix uteri is to the knife and to the actual cautery. So, in the great majority of cases of cervical cancer, pain, as an exacting symptom, is absent in the earlier stages, and it claims attention only when the disease has attacked the sensitive uterine adnexa, or the still more sensitive uterine cavity. In some cases in which the endometrium has been invaded, the suffering is often excruciating, and I shall never forget the agony of one of my patients. For some weeks before her death she had to take daily by the mouth from 20 to 35 grains of morphine.

On the other hand, I have known women to die from the ravages of this cruel disease, who complained of nothing more than the ordinary female backache—that misleading canonical sacral pain from which every woman at some period of her life suffers. Hence, pain, especially of the lancinating variety, is not to be looked for as an invariable accompaniment of this disease. Most certainly it should not be considered pathognomonic of it.

Nor can the vaginal discharges be deemed more trustworthy evidences of malignancy. At the beginning, and often long after the onset of the disease, the discharges are not only not fetid, but they

present no characteristic features whereby they can be distinguished from any ordinary leucorrhea. Later on, they usually become tinged with blood, like meat-washings; but even then they may be wholly free from any putrid odor. In point of fact, in its early stages there are no such tell-tale symptoms as would arrest the attention of the woman and arouse her alarm.

A digital examination is the only trustworthy way of arriving at a correct diagnosis, and this should never be neglected in any case of painful coition, stubborn pelvic pain, free leucorrhea, and especially of irregular uterine hemorrhages. In point of time a persistent leucorrheal discharge precedes every other visible symptom; but this is a disorder so common to the sex that it is generally disregarded. Irregular hemorrhages are practically the first appreciable manifestations of the disease, and they should always be looked upon with suspicion, especially when the woman is over thirty-five, and has borne children—I repeat it, *when she has borne children*—because, as previously stated, a cervical tear is the most common cause of malignant disease of the cervix.

A show of blood, however slight, following sexual intercourse should awaken suspicion, for it ought to convey the meaning that the male organ hits an open sore. Increased monthly flows, or the appearance of inter-menstrual shows, or blood-dribbling after an unusual exertion at the climacteric period, are warnings of grave import. But, perhaps, the most significant danger-signal of all is a counterfeited renewal of menstruation after its ces-

sation. For instance: A woman at the age of forty-five ceases to menstruate; yet two years later she begins to have vaginal hemorrhages. Now, instead of being alarmed at these untimely shows of blood, the woman usually accepts them as a return of her monthly periods, and joyfully interprets them as meaning her rejuvenescence. Here, let me in one word say, that the traditional belief in climacteric hemorrhages, as such, is a delusion and a snare. The climacteric is not an entity that of itself begets the hemorrhages attending the change of life. But the carcinomata, the polypi, the fibroid tumors, the uterine vegetations, which start into activity in and about that period of life—these are the factors—these the entities. Irregular hemorrhages, then, at or after the menopause, are truly the red lights of warning to the alert physician, who will at once urge a vaginal examination, both for his own credit and for the sake of his patient.

In its earliest stages a carcinoma of the cervix usually appears as a hard nodule under the mucous coat of a torn cervix. Soon this breaks through its envelop and forms an open and indolent ulcer. Sometimes the exuberant vegetations on this sore cannot be told from the cockscomb granulations of a bad cervical tear, or indeed from those of a syphilitic ulcer, and the aid of the microscope may be needed. But usually the diagnosis is an easy one. The sharply defined rim of the crater-like sore, the friable vegetations that bleed on the slightest touch, and the dense hardness of the surrounding cervical tissue, tell the sad tale with unerring accuracy.

Whilst in the very large majority of cases, malig-

nant disease of the cervix is the rule, yet malignant disease of the endometrium or of the body of the womb occasionally happens. It will then be met with under the form of sarcoma, of papilloma, or of epithelioma. Senile endometritis tends to this form of malignant degeneration, and it should, therefore, be combated at the outset. This is best done by the use of the sharp curette and by the subsequent packing of the uterine cavity with iodoform-gauze. Old maids and sterile wives are usually the victims. But fruitful women who have ceased to bear are not wholly exempt from supra-cervical carcinomata of the womb. In my private hospital, about a year ago, I successfully removed such diseased wombs from two ladies. One had borne three children and was fifty years old. The other one had given birth to ten children and had reached the age of sixty-three. In these two typical cases, neither a digital nor a speculum examination revealed any evidence of malignant disease. The cervix appeared perfectly healthy, both to the finger and to the eye. But in each one an obstinate leucorrhea had prevailed for a long time, followed later on by irregular blood-dribblings that lasted for several days at a time. The diagnosis was made by the curette, which removed bodies like boiled tapioca. This was confirmed by the microscope, which revealed in the one the cells of papillary carcinoma, in the other those of epithelioma. In neither of these cases has the disease returned.

These cases of cancer of the body of the womb are more successfully dealt with than those in which the ulcer begins on the cervix. The disease is less

likely to return, for two reasons: Firstly, because the ulcer or the malignant growth, from its position, more slowly invades adjacent structures, and is, therefore, more likely to be limited to uterine tissue. Secondly, because the woman, in these cases, has usually passed the climacteric, and the disease then is less liable to return after extirpation of the womb, than during the period of menstrual life, when the womb is more vascular and more succulent.

To sum up: In order to make an early diagnosis of uterine carcinoma, the physician, wholly ignoring the climacteric as an entity, must insist upon a digital and a speculum examination whenever his patient complains of any untoward or any unwonted pelvic symptom. More is learned by the finger than by the speculum, for in these cases one can feel more than one can see. Besides this, the speculum is liable to break off crumbling growths and to set up a troublesome hemorrhage. If the cervix is sound, and the discharges, whether bloody or leucorrheal, come from the uterine cavity, the curette must be used as an aid to the diagnosis. In all cases of doubt the microscope will render efficient help. When the diagnosis has been made, and that early enough to find the growth limited to the womb, there remains to the physician but one more duty—he must urge the immediate removal of the womb.