I am a little skeptical of the value of simple opinions, but I suppose that opinions are the best we can hope for when statistics do not exist.

(1) The preservation of the uterus for the use of additional radium is of value only when, the cancer has spread to the peritoneum, but it has not spread beyond the true pelvis, i.e., within range of the radium which is put into the uterus.

Total hysterectomy is the logical operation, since extension to the paramentria or the iliac lymph nodes (without extension elsewhere in the peritoneum) is exceptionally rare. The omentum may be removed, as a palliative measure if it is involved. The removal of the omentum, as a prophylactic procedure, is not reasonable since it is unlikely that the only microscopic implants would be on this organ, thus making its removal of significance in the end results.

With respect to the removal of large masses, when the case is not completely operable, there is no single answer. If large masses are rather readily removable (as for example, in the case of cysts with light adhesions), these should certainly be removed at the time of the primary operation with the radiation afterwards. It is obviously absurd to leave a readily removable mass in the abdomen simply so that it can receive X-ray therapy. On the other hand, if masses could only be removed at the risk of hemorrhage or damage to organs, then the abdomen should be closed, X-ray should be given and a second operation attempted later.

I am certainly of the opinion that the removal of large masses, either before or after X-ray, increases the life expectancy as compared with the patient who is simply explored.

(5) (a) Radium application in the vagina or in the uterus is only significant in the rare case in which the only implants are located in the true pelvis within the range of radium so placed.

In general, we prefer supervoltage and in this Institute we are using telecobalt, the X-ray beam of the betatron and a 2000 mev X-ray machine without evident preference. I do not believe, however, that statistics have completely demonstrated the advantage of the higher voltages over conventional X-ray therapy. Equal treatment can certainly be given with less skin damage with the higher voltages.

The intraperitoneal application of radioactive isotopes has in general been disappointing in our hands. No one has, or will be able to demonstrate, that it has a prophylactic advantage in those cases in which the cancer was apparently completely removed by surgery. In a few cases, we do believe, the comfort of the patient is increased by control of ascites by radioactive isotopes.
This department has tried a number of antimetabolites and cytostatic agents and has published some of these results. In spite of somewhat favorable written reports, we remain skeptical as to whether any real palliation is being accomplished. The course of this disease being extremely variable, it is very difficult to decide whether a few months of apparent improvement are the results of any specific therapy. We continue to use these agents in some cases, but often chiefly as a result of the insistence of the patient or her family. We do not believe that there are any such agents available at present which contribute significantly to the treatment of carcinoma of the ovary.

The answer to the previous question is still more apparent, when we speak of the combination of a therapeutic and a radiation regime. We have not ventured the critical test, which I believe is to apply a chemo-therapeutic agent before radiation. Chemo-therapeutic agents after radiation seem not very useful.

(6) Prophylaxis: The age at which normal ovaries are removed at the time of a hysterectomy for benign conditions of the uterus, seems to be becoming constantly older. But in general, I think, that ovaries should not be removed before the age of 40. Between the age of 40 and 50, the decision should depend to a considerable extent upon the patient’s own wishes after the alternative possibilities of an early menopause and the small statistical risk of a later carcinoma of the ovary have been explained to her. The patient’s psychological reaction to the idea of a bilateral coherectomy seems to me to be the decisive point during this decade. After the age of 50, the prophylactic removal of the ovaries should be rather strongly advised, but even then not insisted upon by the surgeon in every case.

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