Jean Cohen’s corner

Raoul Palmer: a maker of fate

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Abstract

The privilege of old age is to possess a synthetic view over the past and to appreciate the evolution of decisive and determinative episodes in various clinical fields. In my lifetime as a gynaecologist and obstetrician, I have witnessed wide changes in contraception, epidural anaesthesia in obstetrics, IVF, and so on … Each time, these revolutions were sustained by men and women of exceptional stature. One such revolution concerned the introduction of laparoscopy into clinical practice. To this end, I wish to tell the story of one of my professors who was a determined pioneer in its development.

Keywords: coelioscopy, gynaecology, laparoscopy, ovarian biopsy, surgery

Today, one may have difficulties in figuring out exactly what being a gynaecologist was like in the late 1930s before the Second World war. Diagnoses were based almost exclusively on the interpretation of clinical symptoms. This led to errors in the diagnosis of ectopic pregnancies, pelvic infections or tumours (to quote only some of the diseases). Only exploratory laparotomy, with its own complications, was able to rectify errors. The need for routine dosages was never explored, and hysterosalpingography was still searching for its norms. In 1934, Professor Robert Proust spotted a young clinician to whom he gave the title ‘Responsible for researches and explorations in gynaecology’. This is how Raoul Palmer was able to achieve successive improvements in patient care over the following years, including the interpretation of the thermic curve (basal body temperature) in 1934, hysteromanometry in 1937, the study of cervical mucus in 1938, utero-tubal insufflation in 1939 and the hormonal diagnosis of ovulation and the role of the corpus luteum in 1941.

However, something was lacking in these endeavours. This involved the direct vision of ovulation and the formation of the corpus luteum. Accordingly, Raoul Palmer’s determination perfected laparoscopy, also called ‘coelioscopic’ in France. Whether we define ‘laparoscopy’ as the endoscopy of the pelvic cavity, or the preliminary distension by an artificial pneumoperitoneum, credit as the inventor of the method must be given to Kelling from Dresden. He practiced it on a dog and named the procedure ‘coelioscopy’. The first to try it on a human was Jacobeus from Stockholm in 1912 who named it ‘laparoscopy’. He did not use a pneumoperitoneum and essentially practiced it on ascetic patients in order to evacuate the ascetic fluid. In the 1930s, laparoscopy of the upper part of the abdomen encountered varying successes with Steiner and Ruddock in the USA and Kack in Germany. Applying laparoscopy to the pelvic cavity and gynaecology was performed sporadically by Orndoff in Chicago, and by Anderson in New York. Ruddock and Hope were able to diagnose ovarian cysts and ectopic pregnancies. In fact, pelvic exploration was complicated by the fact that female genital organs tended to fall backwards, even in the Trendelenburg position, so only their superior pole could be seen. This is why Decker, in New York in 1944, proposed the use of culdoscopy under local anaesthesia for patients in ‘knee chest position’.

In 1944 (during the war), laparoscopy as practised by Palmer involved placing a nozzle in the uterus in order to lift and displace it. His first optical tool was a MacCarthy resectoscope of 3 mm diameter with a bulb of the shape and size of a grain of wheat at its terminal end. This approach provided a very dim light in the abdominal cavity. In 1946, technical details were presented to the Academy of Surgery, Paris, by Professor Mocquot. The pneumoperitoneum was established by infusing CO₂ into the abdominal cavity, utilising an ideal pressure of 15 mmHg. The needle used for establishing the pneumoperitoneum was introduced under the left side of ribs. Local anaesthesia was applied, but the patients long remembered their discomfort, so general anaesthesia was offered from 1952 onwards. In 1946 and 1947, Palmer had performed 50 coelioscopies and in 1954 he reported on 250 cases.

In 1950, Raoul Palmer published a book Involuntary Sterility along with Elizabeth Palmer, his wife. Today, infertility is the topic of a university degree and benefits from a 100% refund from social security. Back in 1950, it needed Raoul and Elizabeth Palmer’s genius and great experience to write such a considerable and learned study that is still read today. Fifty years later, it still maintains its interest and accuracy in updating data.

As early as 1952, Palmer used Fourrestier’s endoscope. This was based on the use of a stick of quartz to transmit a powerful light of 150 watts into the abdominal cavity from a cold light source placed in a case external to the abdominal wall. At this time, as the Hospitals of Paris had appointed me as extern and then intern, I was working with Palmer. Laparoscopies took place in a small room on the ground floor, overlooking the gardens. In summer and on very hot days, its windows would be wide open. Boiling water was available all day long from a long pan and the optic apparatus would be placed in it during the interval between two laparoscopies. On occasion, out of sheer
clumsiness, the quartz stick would break despite it being worth a fortune! Then we would return to the Guerin apparatus, which had to be powered up to the maximum to give sufficient light. This led to the over-consumption of those little bulbs, held in reserve in sterile boxes. In exceptional circumstances, we would lose the bulb while operating and would have to recover it with a forceps.

After 1956, Frangenheim in Germany (who perfected light transmission by means of glass fibres), and we in the Hopital Broca in Paris, had numerous visitors including Cittadini from Italy, Steptoe from Great Britain, and Melville, Cohen and Neuwirth from the USA. All of them published the results of their experiences in the following years.

Laparoscopy had now become a technique recognized worldwide, but practised only by a small number of gynaecologists. Just as Patrick Steptoe in the UK, Raoul Palmer was highly very much criticized for the ‘theoretical risks’ he was taking with the patients. Today there is a distinction between diagnostic laparoscopy and operative laparoscopy. Yet, as early as 1951, Raoul Palmer had started adhesiolysis. From 1958 on, he performed tubal sterilizations with electrocoagulation. In 1964, we published on the ovarian biopsy forceps and the technique, permitting the correct approach to ovarian biopsies. Years later, Raoul Palmer’s students and many other surgeons in the world finalized the use of operative laparoscopic gynaecological surgery. Palmer’s great experience and his immense knowledge had brought visiting gynaecologists worldwide to his side for varying periods of training. These visitors later became his friends. Palmer also trained many French students and one or several students from numerous countries. Let me name among others: Alfonsin from Argentina, Nelson Donadio from Brazil, J. Rioux from Canada, Gordji from Iran, Sharf from Israel, Neuwirth from the USA. Raoul, this ‘Master Teacher’, was passionate, rich in knowledge and understood the most unexpected facts. He was sceptical in front of novelty, and would answer back with deliberation when he wanted time to think. His intuition was also exercised on difficult diagnoses, or as new theories or new treatments were adopted. Thanks to him, I met Elliot Phillip who wrote in 1986: ‘Honours came to him and though he appreciated them, and in particular the FRCOG ad eundem awarded him by the Royal College of Obstetricians and Gynaecologists in London in 1974, his shy smile if one mentioned it revealed his innate modesty’ (Phillip, 1986).

Raoul’s example has been decisive on numerous occasions for many among us. We admired him, loved him as a father figure, and still maintain an everlasting veneration. As he seldom talked of politics, one may have thought him as being less concerned by societal problems, and less involved in contemporary conflicts. Yet, in 1963, he reported on contraception to the meeting of the French Society of Gynaecology (contraception was then forbidden in France). He was then accused by the French Council of the Order of Medical Doctors for his defence in favour of the woman. In 1977, he became the President of the National Association for the Study of Voluntary Sterilisation.

Until almost his last days, this man Raoul Palmer continued his participation in all major debates on gynaecology in France and in all related international scientific meetings. He died on 6 July 1985. A few days before his death, I returned from the first ESHRE Congress in Bonn and was able to tell him that he had been appointed as the first Honorary Member of ESHRE.

Reference

Phillip, E 1986 Correspondence. *Journal of Obstetrics and Gynaecology* 6, 204.