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FURTHER EXPERIENCES IN THE MANAGEMENT OF UTERINE DISPLACEMENTS.

Presented to the Section of Obstetrics and Diseases of Women, at the Forty-ninth Annual Meeting of the American Medical Association, held at Denver, Colo., June 7-10, 1898.

BY AUGUSTUS P. CLARKE, A.M., M.D.

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I have been prompted to present this subject on account of the misapprehension which, I believe, has prevailed respecting the character of an abnormal position of the uterus, and the method of treatment that should be adopted for the correction in certain cases.

It has been a frequent occurrence to meet with cases having a marked backward displacement where a pessary had been inserted and worn for a considerable period without an attempt being made to overcome the adhesions and to restore the organ to a position as nearly normal as possible.

For convenience in treatment, uterine displacement may properly be divided into two classes, namely: anterior and posterior rotation.

I have often found the former division to yield quite readily to dilatation and to the maintaining of the patency of the cervical canal; this can be effected by the employment of a glass drainage-tube while the patient is kept in a recumbent position. In those cases in which there is much congestion or inflammation of the uterine canal or of the tissues connected with the appendages, douches or other local applications should be used previous to dilatation and drainage.

Of the two results that follow anterior displacement, I have noticed that sterility has been the more common condition or has not been as easy to control as has dysmenorrhea.

Within the past year I have observed an unusual number of cases of sterility dependent on a pre-natural closure of the uterine cervical canal. In one case my records show that the patient had some eight years before given birth to a child: the ante flexion of the corpus uteri was of the third stage, or of an angle about forty degrees. In endeavoring to effect dilatation I found that there existed much hyperplasia of the cervix, which was evidently the result of an old endometritis. An innocent-looking exudation taken from the cervix, when placed under the microscope, revealed the presence of gonococci, the existence of which must have been of long standing and must have contributed to the sterility and to the changes that had taken place in the endometrium. Dilatation of the canal, incision of the interior of its cervical portion, curettement, drainage and cauterization with a 60 per cent. solution of chlorid of zinc finally overcame the dysmenorrhea and relieved the essential symptoms.

In some instances I have found that ante flexion resulted undoubtedly from congenital causes. In very marked or aggravated cases I have observed vesical symptoms to arise. The urine may contain a

muco-purulent sediment. After dilatation and other local measures have been tried, a properly fitted Hodge pessary, introduced so as to lift the uterine fundus from the bladder, afforded satisfactory relief.

As regards anteversion, I have found that condition often associated with subinvolution and therefore has been the result of pregnancy and of parturition, laceration of the cervix, and relaxation or inflammation of the uterine ligaments. Dilatation, curettement, and the direct application of iodine and of other alterative agents have proved excellent preliminary measures of treatment. The laceration of the cervix and of the perineum and also of other parts should in due time be attended to.

In two cases of ante flexion of the third degree, pregnancy took place before opportunity for a systematic plan of treatment could be carried out. In one of the cases vomiting of pregnancy occurring after the tenth week became alarming; this, however, was brought under control by rest and by tamponading the vagina so as to elevate the uterus from the rectal, sacral, and vesical tissues. Such vomiting can often be relieved by the milder means used for replacement of the uterus. If, however, there are firm adhesions, as there were in a case to which I was called some months since little can be safely attempted in this respect until after the term of pregnancy has been completed.

It is sometimes said that the stimulating effect of pregnancy tends to improve the development of the uterus and thus to overcome the ante flexion. In one of my patients, notwithstanding pregnancy went twice to full term, the ante flexion recurred soon after each parturient process had taken place.

As before remarked, I have relied in the treatment of ante flexion much upon resort to dilatation, either by the gradual or by the rapid method, as the condition of the case would seem to justify. In regard to the time when rapid or more forcible dilatation should be attempted, much will depend upon the character of the case. If there is evidence of much old hyperplasia, with a pre-naturally small cervical canal, dilatation should be had recourse to as soon after menstruation as it will be deemed expedient to undertake. If, however, the cervix is soft and imperfect in its size and shape and there is a tendency to menorrhagia or metrorrhagia, the operation should not be performed for some days after the flow has ceased.

In dilating the uterus I have noticed that much care should be taken not to exercise too much force in the beginning; the condition of the tissues somewhat above the internal os should not be overlooked. In cases in which there is considerable hyperplasia or induration of cervical tissue, incision of the parts within the canal will be most helpful; the sudden forcible stretching of the tissues without incision is liable to be followed with delay in recovery or with other untoward results. In cases in which there is a complication of salpingitis, ovaritis, or other inflammatory processes, rest and preliminary treatment should be tried before the more radical measures are employed.

In all cases, after dilatation has been effected, the patient should be kept for a considerable period in the horizontal posture. If sterility or dysmenorrhea continue, dilatation, curettement and intra-uterine applications should be repeated at proper intervals. I have found, however, that when treatment was seasonably undertaken, favorable results in a large percentage of cases were early achieved.

In the management of retroflexion we have been accustomed to speak of the corpus of the uterus as being bent or turned backward from its original position. In this connection it might be proper to say that the cervix of the uterus is in its normal position when its axis is nearly at right angles to the axis of the vagina and the corpus inclined forward toward the abdominal wall. The degree of retroflexion may then be determined by finding the measurement of the angle that is formed by the backward displacement of the body from the internal os. We may have a retroflexion that embraces an angle varying from the dimensions of half a circle to those that are included in less than a quarter of an arc. As regards the treatment of such cases many points have to be considered. Of course, replacement of the organ must first be accomplished and its reduction must be maintained. I will not discuss the question of repair of the lacerated cervix or of an injured perineum, for we all now recognize that such cases should receive proper attention, as well as that measures should be instituted to overcome the condition of subinvolution. The cases that of late have given the most trouble have been those in which the organ was firmly bound down by adhesions, or after the adhesions have been overcome, the ligaments and other parts have been found so weakened and relaxed as to fail to act as guys in sustaining the organ in its restored position.

As we come to appreciate more and more the influence of intra-abdominal pressure in the maintaining of the uterus in its normal position, we shall perceive more clearly the reason why we have succeeded in some cases by a resort to a special method of procedure, while in other cases such operations have proved to be almost entirely useless.

Last winter there came under my care a case in which Alexander's operation had been tried some three months previously without any beneficial results being apparent. I found, on further examination, that the retroflexion was of nearly the third degree. Some dysmenorrhea was complained of, besides the effects of pelvic pressure and other annoying symptoms, the result of reflex irritation. The vulvo-vaginal introitus was relaxed and patulous. The only operation that I could recommend was Hegar's method of posterior colporrhaphy. The posterior vaginal wall was narrowed so as to overcome the patency of the vulval opening, and thus to prevent the ready ingress of air. The uterus was then kept in place by a properly fitted Hodge pessary, though the round ligaments were much relaxed, and no attempt was made to shorten them.

I believe that Alexander's operation is the most useful in those cases in which the vulvo-vaginal wall is so intact as to be sufficient to maintain the intra-abdominal pressure. There can be no doubt that had the perineal and vaginal tissue been repaired at the same time that the operation was undertaken for shortening the ligamenta rotunda, the results, in all respects, would have been typical of the benefits that could have been achieved by necessary operative interference.

Those cases in which the uterus is displaced backward and is firmly adherent, are frequently the most troublesome to manage. Manual and instrumental interference may sometimes be helpful in effecting the proper reduction; so, also, will repeated tamponading with iodoform gauze or with prepared lamb's wool, but these procedures have many times proved

to be tedious measures of treatment. In such cases, Alexander's operation will have to be deferred; this operation would be especially contra-indicated if the adnexa were prolapsed and adherent also. The course then to be pursued will depend on the amount of suffering.

If the severity of the symptoms cannot be relieved by resort to milder means, or by the recourse to the extra-peritoneal method, ventrofixation or ventrosuspension may, of course, be the next expedient. Before resorting to this measure of proceeding it is highly necessary to be certain, as it is in Alexander's operation that the perineum and vulvo-vaginal tissues are intact, and that there exists in those parts no patency that would materially overcome the equipoise of the intra-abdominal pressure.

On making an abdominal incision other factors as contributing causes of the retro-displacement may be discovered; these will have to be dealt with as may, in each individual case, seem proper. Ventrofixation as a routine method of treatment for correcting retro-displacement of the uterus can, according to the present knowledge of the results of abdominal surgery, be scarcely approved. The operation in certain cases has its peculiar benefits; in others it has its exceeding limitations. Ventrofixation or ventrosuspension, I have found, is an admirable surgical expedient in those cases in which one or both of the appendages or portions of the broad ligament have been removed through an abdominal incision; for overcoming retro-displacement in married women, I believe that it is best that the operation should, if possible, be deferred until the approach of the menopause. If conditions admit of a choice, Alexander's operation for shortening the round ligaments in properly selected cases is no doubt the less dangerous to the patient's life and the less likely to interfere with the normal evolution of pregnancy, though I have seen a few cases in which utero-gestation, taking place at an early date after the operation, terminated about the sixth month in premature parturition.

DISCUSSION ON PAPERS OF DRS. GOLDSPOHN AND CLARKE.

Dr. JOSEPH EASTMAN, Indianapolis—I desire to thank Dr. Goldspohn for his excellent paper. I endorse every word I heard, although I did not enter the room until the paper had been well begun and the foundation had been laid. The paper certainly shows that the Doctor is studying along anatomic lines in a conservative way, and with the absolute view of effecting cures, and not for the sake of making new experiments or developing new modes of operating.

Dr. HOWARD A. KELLY, Baltimore—Some of you may recall a paper in the *British Gynecological Journal* in 1889 with reference to stitching up the ovary with its attendant prolapse. I myself have never felt perfectly clear as to the pathologic significance of those ovaries that were felt with unusual distinctness in Douglas' pouch, and I have never felt warranted in opening the abdomen for the sake of stitching up such ovaries. When I have opened the abdomen for other causes these ovaries have never appeared to be diseased; they may have had small cysts in them. I shall watch with interest the effects of operations upon descended, prolapsed, more or less tender ovaries. In the course of abdominal operations, where I have removed the tubes, and the ovaries have tended to drop back, I have pinned them to the cornu of the uterus in a number of instances. It is interesting to note the varieties or differences we find in the course of operation in the utero-ovarian ligaments. Of course, the length of the ligament allows the ovary to drop back. I have seen a case within the last two weeks in which the ligament was over two inches in length. That was in association with a tumor, which was large. When the ligament was pulled out I never saw one as long before. I have seen them short and thick. I wish to say in this connection, that a short time before I came here I saw a case where there was absolutely no utero-ovarian ligament. The appearance was curious. In opening the abdomen and exposing the

uterus, saying this *à posteriori*, the ovary was plastered right on to the uterus on both sides for about two-thirds of its surface, the scar tissue looking like skin that had been in water for some time, radiating several centimeters around. This was the only case in which there was absence of the utero ovarian ligament.

Dr. WILLIAM H. HUMISTON, Cleveland—In reference to cases of prolapsed ovaries, I find it is a great question for me to decide as to the necessity for an operation. I do not feel clear in deciding to operate until I have gone through a course of treatment in these cases. It is rare for me to find an ovary prolapsed unless we have descensus or a retroposition of the uterus. In those cases I find that the history gives an indication as to what the result may be from ordinary treatment. If the case has existed for a long time, usually it has failed to be permanently benefited by putting the uterus in its proper position and condition. But I feel like trying the conservative method always in doubtful cases before resorting to surgical procedures. I find in a great many of these cases, if the symptoms have been only a year in duration, that they do get well by placing the uterus in its proper position and supporting it there with rest in bed, hot water douches, by glycerin pads, and with medicated boro-glycerid, or ichthyol-glycerin solution. I have never done the operation of suspending the ovaries, for after failure of the conservative method of treatment, the symptoms not being relieved to any extent, upon opening the abdomen and inspecting the appendages I find them in a pathologic condition, and then removal of them is the only thing to give permanent relief, and in those cases I have had most pronounced success. Many cases that have come to me with symptoms of recent date, say within a year, have been permanently cured by the ordinary treatment with pessary, after six or seven or ten weeks of support by pessary. The uterus remains in its position and we have no further trouble. Usually pregnancy takes place and they go on to full term without any trouble. Where the appendages are not diseased, merely congested, and the ovaries prolapsed, perhaps the conservative treatment has been usually sufficient in my experience.

Dr. E. GUSTAV ZINKE, Cincinnati—I can not believe that an otherwise healthy ovary or ovaries that are prolapsed, even though they be lying behind the uterus or in front of it, will give rise to any serious symptoms—certainly any symptoms that would in my opinion justify operative interference. This is the view which I take of this procedure. I have yet to see a single case of prolapse of the ovaries without adhesions that has given rise to such symptoms as will warrant operative procedures, except perhaps such as a patient may be put in the genu-pectoral position several times a day for as long as she may stand it in connection with the use of tampons, keeping the organs in their place as much as possible; but when I have found relief from measures of this kind, I always feel sure that whatever symptoms there were present they were not the result of adhesions, and in no case were they so severe as to justify an abdominal section for the purpose of stitching the ovary in its proper place.

Dr. J. H. W. CHESTNUT, Philadelphia—My experience in these cases coincides very clearly with that expressed by Dr. Humiston of Ohio, and Dr. Zinke. The numerous cases I have seen have been so comparatively insignificant in their ulterior influences that I have not yet been called upon to operate for removal of the ovaries except where there were evidences of intrinsic disease. The frequent placing of the patient in the knee-breast position, the retention of the ovaries in their position by tampons medicated by glycerin and ichthyol and rest in bed with the hot douche will give relief. Where there have been adhesions I have felt compelled to remove the organ. I have no doubt, however, that there are cases in which this procedure will be of value.

Dr. MILES F. PORTER of Fort Wayne, Ind.—There are certain cases of prolapse of the ovary in which we know the shortest and best method of treatment is some method of fixation or their removal. With the Goldspohn method I have had no experience whatever; but I have had some happy results from abdominal fixation of the ovaries, in cases where apparently there was absolutely nothing wrong save that the ovary was out of position—sometimes out of position one day and in position the next. A few days ago a case of this kind presented itself which had been treated by the usual method without result, and upon leaving she remarked to me that the first movement of the bowels without pain and without distress, she had for a period of eighteen months, she had had within three months after the ovary was put in position, and retained there through an incision in the median line.

Dr. CHARLES I. BONFIELD, Cincinnati—It seems to me that the experience of Dr. Kelly and of Dr. Zinke that these cases

do not cause some trouble must not be the experience of the entire profession. The cases that are attended with retroversion of the uterus, and the cases that are relieved when the retroversion is relieved are amenable to the office treatment so graphically described by Dr. Humiston of Cleveland. But when the ligaments of the ovary are so stretched that replacement of the uterus does not also replace the ovary, then it has been my experience that local treatment is very hard to carry out, and it is almost impossible to make it effective. A great many of the gentleman have said that the ovaries, if not diseased, need not be disturbed; but it has been my experience, after watching these cases, that if I am not able to relieve them in any way, sooner or later the ovary itself becomes diseased; the malposition of it interferes with its nutrition, and sooner or later we have a diseased ovary which requires its removal. The gentleman who spoke a minute ago, from Iowa (Dr. Fairchild), voiced my sentiments when he said that certain women could not afford to be treated months for this condition, such as school teachers, music teachers and clerks in stores. They cannot afford to pay money for their care, nor can they afford to rest long enough to get temporary relief. In those cases some surgical measures are indicated.

Dr. E. GUSTAV ZINKE, Cincinnati—It is possible I have placed myself in a wrong position because I was not here when the paper was read. I may not have been correctly understood with reference to what I had said before. What I meant to say was that when we have a perfectly healthy ovary, in other words, no diseased condition in the pelvic cavity, only prolapse of the ovary, that the symptoms arising therefrom can not be sufficiently severe to warrant operative interference. Furthermore, when I spoke of the genu-pectoral position for the relief of the condition, everybody knows that there are no adhesions present. The treatment need not be very protracted, and a few applications will probably be sufficient. If protracted treatment becomes necessary, it is evidence that adhesions exist, and that other pathologic conditions have arisen for which operative interference will be perfectly justifiable. I wish it distinctly understood that I endorse every honest effort. I do not know whether Dr. Goldspohn does this operation for prolapse of the ovary without any diseased condition present or not. I simply make these statements in order to make myself understood. I hope if I did not make myself understood then I have done so now.

Dr. JOSEPH PRICE, Philadelphia—My experience has been instructive and interesting in this line of work, although I have not resorted to surgical procedures except in the presence of pathologic conditions. A prolapsed ovary with fixation commonly has occlusion with retention, and the same holds good with retrodisplacements with fixation. It is exceptional to find a fixed uterus without an occlusion with retention of blood, pus or water. You have alluded to the importance of surgical interference in this class of cases. For simple descensus of either or both ovaries, or the truant ovary of the Germans, we have had a great variety of treatment. I do not approve of the office treatment. It avails but little. If you are going to treat a case successfully you must put the patient at rest, and if the treatment be local and general you will succeed in many cases in giving marked relief by some of the methods recommended. The globe trotters and the class of women who do not want to be mothers, or prefer postponing the treatment of their troubles for trivial purposes or other convenience, are the ones that annoy us most. If you can convince some of these women that they should become mothers you will, in many cases, cure the truant ovary. Before leaving home I examined a patient who has not conceived for eleven or twelve years. She is living in the extreme Northwest; she was the victim of artificial methods of preventing conception, and, as a consequence, had marked nervous disturbance bordering upon insanity. I found in her case, large, congested uterus and truant ovaries. I put her to bed, corrected the displacement of both ovary and uterus, and she returned eight months later to ascertain the presence or absence of pregnancy. I assured her that she was pregnant some four months or more. She went away rejoicing. We are burdened in the East by a number of cases traveling all over the world. They have an unnatural dread of having a baby, and a baby is a thing we love down East above all things.

Dr. CLARKE (closing the discussion on his part)—In most cases where we have displacement of the adnexa we have displacement of the uterus, and in my paper I spoke of the importance of intra-abdominal pressure, and I believe we should in all cases endeavor to restore that. There is a class of cases in which I think my methods of treatment should be of avail, but I have seen some cases in which ventrofixation or ventrosuspension has been undertaken and carried out with so little good effect, that I am afraid of it. I believe if the Alexander

operation is performed in a certain class of cases, and the peritoneum is intact and the subinvolution is overcome, with a little rest in bed, the woman kept in that position, we will get almost a perfect cure. If we perform Alexander's operation without restoring the parts to overcome subinvolution and without watching the condition of the ovaries and tubes we will meet with failure. The purpose of the round ligaments is to prevent backward displacement, and to fasten the uterus to the abdominal walls or to the peritoneum has, in my experience, been a failure in those cases in which the tubes and ovaries have been removed.

Dr. GOLDSPOHN (closing the discussion)—I condemn the surgical monstrosities of ventrosuspension, ventrofixation and vaginofixation. Direct or immediate fixation of the uterus to the abdominal wall, without an intervening band, is so serious a thing that soon it will be malpractice to perform it in women who may conceive. Suspension exposes the patient to the risks of intestinal obstruction. If the bands made by these operations were the result of anything else, the operators themselves would open the abdomen to remove them. The records show that two-thirds of the women subjected to these operations have troubles in gestation or labor, or both. The harvest of ileus after ventrosuspension has only begun. The round ligaments are merely guy-ropes. Intra-abdominal pressure is the holding force that either supports the normally anteverted uterus or condemns the retrodisplaced uterus to remain permanently in that position. The best way to correct these displacements is by means of the round ligaments and through the inguinal canals. The cardinal points in the technique of Alexander's operation are that the way into the abdomen is not to be cut, but the tissues are split so that they fall together afterward; that the conservative operations upon the appendages can be done through the dilated wound, and that each layer must also be closed individually. At least 95 per cent. of the cases of descent of ovaries are associated with retroversion of the uterus, and hence the treatment must be directed to the displacement of both. The gynecologist who knows no middle ground between amputating an ovary and doing nothing, stands in the same position as the surgeon who would amputate every diseased leg. I never do Alexander's operation without curetting thoroughly and repairing the cervix or perineum, or both, at the same sitting, if at all required. My technique of the operation is briefly as follows: The pubic spine and Poupart's ligament are the guiding points. An incision is made half an inch above the ligament, beginning near the spine, passing down to the aponeurosis of the external oblique. The bunch of fat in the external ring is grasped with forceps and a finger is placed in the ring. The aponeurosis is then split up without being cut, and is held aside by retractors; the round ligament is traced to the internal ring by tearing the attachment of the deeper muscles to it, when the end of Nuck's canal can be seen. This is cut slightly and a pedicle forceps is introduced and the internal ring is stretched so that the index finger can be introduced. With this all adhesions to the uterus and to the tube and to the ovary of the same side are severed. The ovary and tube, if abnormal, are brought out, inspected and their condition is corrected surgically if possible, or they are removed. The round ligament is sutured to the under surface of Poupart's ligament, in the act of closing each layer in the wound separately, and after the principle of Bassini hernia operating.

THE TREATMENT OF AMBULATORY GYNECOLOGIC CASES.

Presented to the Section of Obstetrics and Diseases of Women, at the Forty-ninth Annual Meeting of the American Medical Association, held at Denver, Colo., June 7-10.

BY DENSLOW LEWIS, M.D.

CHICAGO, ILL.

Sanger tells us that gynecology is the surgery of the female genitalia. His definition is neither exact nor complete, but it is clinically useful. As a matter of fact the first thing to be determined in every gynecologic case is the advisability of operation. A necessary subdivision of the question is at once apparent. There is the consideration of immediate operation at the time of examination, the operation in such cases being trivial. There is to be considered the advisability of local and systemic treatment, which is often to a great extent tentative, with the reasonable hope

that surgical treatment may ultimately be dispensed with or may become relatively insignificant, at least not especially dangerous, and finally, there is the certainty that operative measures are imperative, perhaps that their immediate adoption is the only known means of relief or of saving life, in which event removal of the patient to a hospital is usually indicated. There is, therefore, in the first examination of every gynecologic patient a chance for much difference of opinion, both as regards the indications for operation, the kind and extent of surgical measures to be adopted, as well as the relative value of measures, chiefly medicinal and topical in character, which include no extensive surgical interference.

I desire in this connection to refer to the gynecologic cases I have seen at the Chicago Polyclinic during the past four years. I ask your attention exclusively to those cases, very properly designated as ambulatory, where the women, although often seriously diseased or suffering from a condition which seems to demand surgical treatment, are unable to submit to radical measures which would necessitate sojourn in a hospital or cause them to give up their daily work. These patients are chiefly working women, many of them having to support children and at times a husband. If not employed in some shop or factory they are obliged to attend to household duties, from which they can not absent themselves without serious interference with the routine of their family life. In some instances they are impostors. I have known them to come several thousand miles for treatment. They have settled down in Chicago with their families and have taken advantage of our dispensary and hospital facilities in the most shamefaced manner. Prostitutes are not frequent attendants of our gynecologic dispensary. The women, as I have said, are, as a rule, obliged to work for a living. They are often poor, but not destitute. They are, most of them, trying to do their part in the struggle of life. For this reason it is a hardship in several ways for them to remain in the hospital long enough to convalesce from an operation. They can not indulge in the "rest cure," or in many instances, purchase proper food. They seek relief from their ailments without interference with the routine of their daily life. It is gratifying for me to be able to say that often such a course of treatment is practicable and sometimes surprisingly successful. Let me briefly detail the methods in use in the different classes of cases I have been called upon to treat:

Venereal warts if small are snipped off with scissors under cocain anesthesia. Occasionally the base is touched with a drop of carbolic acid. If the warts are large and extensive the patient goes to the hospital for a few days, the strip of mucous membrane from which they grow is dissected off and the edges united, very much as in a Whitehead operation for hemorrhoids. During pregnancy no operation has been undertaken, nor have the warts, as far as known, in any way interfered with parturition. During the puerperium they diminished in size and in some cases they have disappeared. Chancroids are touched with strong carbolic acid for its anesthetic effect, followed by a drop of fuming nitric acid applied with a glass rod. Powdered boracic acid is applied to suppurating surfaces after the parts have been cleansed with a boracic acid solution and dried with absorbent cotton. No case of phagadema occurred. Chancres were not often seen. They occurred on the fourchette and inner surface of the labia majora. They were dusted