ART. XI.—*Case of Retroversion of the Gravid Uterus, Replaced by the Introduction of the Colpeurynter into the Rectum.* By Dr. J. GOODMAN, of Louisville, Ky. (Communicated by Prof. HENRY MILLER.)

THE subject of this case was a healthy, robust woman, thirty-two years of age, the mother of six children. All her former pregnancies had been natural and her labors easy. Two weeks prior to being seen by us, she was suddenly seized, while asleep at night, with a severe pain in the abdomen accompanied by a sensation of weight and bearing down, and upon endeavouring to pass water, found that she was unable to do so. These symptoms continuing, the next morning she sent for her usual medical attendant, who drew off her urine and allayed the pain with opiates. After several days, no improvement being manifest, a consultation was held and an examination instituted, resulting in a diagnosis of ovarian cyst prolapsed into Douglas' *cul-de-sac*, for the relief of which, tapping through the rectum was determined upon. The patient, however, being averse to an operation, delay ensued, and finally refusing positively to submit to it, she was given up by her physicians.

It was at this juncture, thirteen days after the trouble originated, that the patient was seen by Prof. Henry Miller and myself. She was suffering greatly from distension of the bladder, and upon introducing a catheter upwards of six pints of dark-colored, ammoniacal urine was evacuated. An examination *per vaginam* discovered the os uteri high up above the symphysis pubis, while posteriorly, between the vagina and rectum, there was a large, rounded tumour, the continuity of which with the os and cervix was easily traceable. The aspect of the case, so far, impressed us with the idea that it was one of retroversion of the gravid uterus, and upon inquiry, we found that the patient believed herself to be four months advanced in pregnancy, it having been about that length of time since she last menstruated. The diagnosis being thus confirmed, we determined, in the first place, to give the organ an opportunity to resume its natural position by unloading the bowels with an aperient and keeping the bladder empty. This was persisted in for four days, when, no change having taken place, an unsuccessful attempt at reposition was made. It was now evident that more energetic measures were necessary for the patient's relief. Accordingly, on the following day she was brought under the influence of chloroform, and being placed on her back near the edge of the bed, Prof. Miller endeavored by means of the hand, introduced into the rectum, to elevate the fundus above the brim of the pelvis; after a persistent effort, however, in which as much force was used as was deemed compatible with the integrity of the parts, sufficient, in fact, to lacerate the mucous membrane of the rectum and cause slight hemorrhage, he only succeeded in dislodging the fundus to some extent, and rendering it more movable. A medium sized colpeurynter was then introduced into the rectum and distended with air; this produced violent expulsive efforts, to allay which it was found necessary to administer an opiate, but tolerance of the foreign body being at length acquired, the patient was left in a moderately comfortable condition. Upon returning in about six hours, I was delighted to find that everything we had hoped for from the colpeurynter had been accomplished. The fundus uteri had gone up and was now easily felt above the symphysis pubis, and the os was in its normal position within easy

reach of the finger. The patient declared herself entirely relieved, and as soon as the colpearynter was removed voided her urine without the slightest difficulty. In a few days afterwards fetal movements became manifest, and since then (two months ago) pregnancy has progressed naturally.

The interesting features in this case are—First, the occurrence of the accident without any assignable cause, coming on as it did, while the patient was quietly asleep, having passed her water only two hours previously upon going to bed. Secondly, the serious mistake in diagnosis made by physicians of considerable experience, which came very near leading to the performance of so useless and hazardous surgical operation. And thirdly, the conjoint use of taxis and the colpearynter *per ano*; a procedure I would strongly recommend, particularly in cases of sufficient standing for partial impaction to have taken place. The taxis being premised with a view of disengaging the fundus and slightly elevating it so as to procure a lodgment for the colpearynter immediately beneath.

ART. XII.—Case of Vaginismus: treated after the Method of Sims, by Excision of the Hymen and Meatus Urinarius, etc. etc. By JOSEPH WONSTER, M. D., of New York.

Aug. 1, 1867, was consulted in relation to Mrs. G., aged 20 years, married for eighteen months; coitus had during that period been impossible, owing to the excessive irritability and tenderness of the valva, vagina, and surrounding parts.

Upon examination under anæsthesia, these parts were found to be naturally conformed. The uterus was natural, and *in situ*. The hymen admitted of great distension with the two fingers of the right hand forcibly separated; but the irritability returned as the effects of the chloroform passed away.

I deferred operating for two months, owing to the heat of the weather; but, at the end of that time no abatement whatever had occurred in the severity of the symptoms. On the 1st of October I performed the following operation: The patient being under the full influence of chloroform, assisted by W. P. Worster, M. D., and laying her on her left side, the labia well drawn up and separated, I seized the hymen with a delicate pair of forceps, and with a small pair of very sharp curved scissors, dissected out the whole of the ring, about four lines in thickness, including the meatus urinarius. The hemorrhage was slight, and less than I had expected. The hymen was about the circumference of a five-cent piece. The loss of blood having been so slight, I determined to proceed forthwith to finish the remainder of the operation. Placing the patient on the back in the position for lithotomy, I passed the first and second fingers of the left hand into the vagina and extended them to the uttermost; I then made an incision on either side of the posterior wall, obliquely in a line from the sacro-iliac symphysis to the sphincter vaginae, in the middle line. This V-shaped double incision, of depth sufficient to divide the muscular fibre, was continued from the point of junction forward through the raphe and sphincter