

## CHRONIC FIXED RETROVERSION OF THE UTERUS : A PLEA FOR OPERATION.

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THERE has been a great deal written during the last half-century about backward displacement of the uterus. There seems, however, to have been a certain lack of literature dealing with chronic retroversion fixed by adhesions.

It is a very notable fact that retroversion alone is more significant than retroversion with retroflexion. In the former case there is nearly always some inflammatory fixation, the most usual being bands which fix the fundus and back of the uterine wall to the intestines and posterior pelvic wall. Occasionally the condition is caused by cicatricial anterior parametric bands, which draw the cervix forward. Where retroflexion is present there is seldom any inflammatory fixation, but there is usually to be found a large flaccid uterus with stretched ligaments or a tumour in the posterior uterine wall or else some adnexal abnormality.

Different gynæcologists hold different views regarding the best definition of retroversion. Schultze, in his "Displacements of the Uterus," says : "Retroversion of the uterus is the stable inclination of the fundus uteri backwards, the shape of the organ being extended or sometimes slightly anteflected." Other gynæcologists

define retroversion as the backward deviation of the cervical axis from the vertical.

To the student studying for examination exact definitions are important. To the practitioner who understands the positions of the uterus, such exactitude is unnecessary.

The patient who is usually anæmic or (if the expression may be used) "liverish" usually complains of menstrual abnormalities. Excessive menstruation with the passage of clots, metrorrhagia, leucorrhœa of a varying degree, a frequent desire to micturate, backache, constipation, with a general feeling of weight and bearing down in the pelvis are the symptoms most commonly complained of. There may be intermittent abdominal pain due to the adhesions.

On bimanual examination the os uteri is found pointing slightly forwards, no flexion is discernible, whilst with the fingers in the posterior fornix the uterus is found between them and the abdominal hand.

When an effort is made to replace the uterus, in some cases partial replacement occurs, but immediately the fingers in the posterior fornix are removed the uterus falls back to its old position; in other cases no replacement can be effected. What then are the possible treatments?

1. *Palliative Measures*.—These are numerous. Vaginal douches, vaginal tampons of cotton wool lubricated with various emollients, rectal massage, electricity, enemata twice or thrice weekly, Schultze's method of replacement after filling the rectum with water are all unsatisfactory. First, they seldom or never cure. Secondly, they keep the patient a chronic invalid, a nuisance to herself and her family, and the slave of her genitalia for the very long time which it takes even to relieve. Thirdly, if the adhesions are so loosened that replacement can be effected and a pessary inserted, the patient is in a position very

little better than the first. Is it to be believed that such palliative measures will open closed tubes? I have had some opportunities of performing laparotomies where patients had been treated in some of the ways herein described. The results obtained, as seen in the abdomen, condemn the treatment. What then should be done?

2. *Operative Measures.*—These may be carried out by the vagina or by the abdomen. Strassman performs all such operations by the vagina. There is, to the aseptic surgeon, no advantage in this method, whereas the disadvantages caused by the small amount of space in which to work, by the difficulty of hæmostasis and by the danger of bowel injury are great. There is no doubt that the abdominal route should be chosen. Before opening the abdomen, the uterus should be curetted. In such cases, there is always marked endometritis. The advice of the late Dr. Herman and that of several present-day operators who advise against the preliminary curettage seems most illogical. Any other necessary vaginal plastic work should also be done. With the patient in the Trendelenburg position, the abdomen is opened by an incision from the pubes to near the umbilicus, the uterus is caught in a uterine forceps or else by means of a stitch inserted deep in the fundus. The use of a bullet forceps is to be avoided, for it is liable to tear out and leave a gaping wound in the uterus. Having steadied the uterus, the adhesions are separated. Light adhesions may be divided from behind forwards with the hand. Dense adhesions must be incised with blunt-pointed scissors, those containing vessels of any size being ligated. Raw surfaces, wherever possible, should be oversewn. The intestines must be handled gently. Unless care is taken, large openings may be made in the rectum by careless handling

of the adhesions. In some cases injury to the bowel is unavoidable, and the operating surgeon must be ready for such contingencies. Where pus tubes are present they must be removed or the tubes must be resected as seems best. Pus should be taken for analysis in a sterile test tube, or on a sterile wipe, with a view to vaccine treatment. The appendix must be examined, and removed if necessary. Lane's kinks and Jackson's membranes should be sought for.

When all the adhesions are separated, when the adnexa are examined, and repaired if necessary, the uterus must be suspended by the method favoured by the operator. I should like to express an opinion here that from post-operative cases I have seen I do not believe it matters what suspension operation is performed—so long as it is done effectively. Ventral suspension, according to Kelly's directions, or any of the numerous intraperitoneal operations for shortening the round ligaments are all useful when correctly performed.

*Drainage.*—The question of drainage is a vexed one. When there has been exudation of pus or where there is much oozing from separated adhesions, drainage should be employed. This may be carried out by means of iodoform gauze brought through an opening in the posterior fornix and out through the vagina, or else by means of gauze through the abdominal wound. The former is to be preferred for the following reasons :—

- (1) There is less pain in the removal of the gauze.
- (2) There is no opening left in the aponeurosis; hence hernia is less likely.
- (3) When brought through the skin wound the convalescence is, as a rule, longer.
- (4) Drainage is equally good in either direction.

The post-operative treatment in these cases should not differ in any way from that followed in other abdominal sections. The Fowler position should be maintained for three or four days. The gauze in purulent cases should remain in for forty-eight hours. Where it has been inserted because of oozing it may be removed in twenty-four hours.

*Fixed Retroversion and Pregnancy.*—Fixed retroversion is usually regarded as a predisponent to sterility. When this malposition is complicated by pregnancy what may happen?

(1) Abortion may occur. This is the most common outcome.

(2) The adhesions may separate, the uterus may right itself, and full-term delivery may result.

(3) The adhesions may separate and symptoms of hamorrhage or perforation of the bowel may arise.

(4) Anterior development, with its serious consequences, may occur.

(5) Incarceration, with all its dangers, may result.

Bearing in mind these sequelæ of the condition, what is the practitioner to do when consulted by a patient who is found to have a fixed retroverted uterus which is pregnant?

There are four courses to be considered.

(1) Leave the patient alone and trust to luck. This in the face of the eventualities would be nothing short of criminal.

(2) Induce abortion. This is recommended by some. In my opinion there is nothing to necessitate such a serious step.

(3) Endeavour to separate the adhesions by means of

Schultze's method and insert a pessary. The disadvantages of this method have already been enumerated.

(4) Open the abdomen, separate the adhesions, and suspend the uterus. There is nothing against this procedure, and it seems to me to be the only treatment possible in a case of fixed retroverted pregnant uterus.

A patient consulted me eighteen months ago complaining that she had had two abortions, the latter being two weeks before she came to see me. I examined her, found a fixed retroverted uterus, and told her to return for operation in four weeks. She returned in three months, when I found that she had in the meantime become pregnant, and I diagnosed the two to three months pregnant uterus to be still in a fixed retroverted position. I advised immediate operation, to which she consented. Having opened the abdomen, I separated the adhesions, many of which were dense and required ligating, and suspended the uterus. She had a normal convalescence. The remainder of the pregnancy was uneventful, and she was delivered without any complications of a full term child. I intend to treat every case of this sort in a like manner. There is always the remote possibility of abortion occurring, but the chance of grave issue, if the patient is left alone, is far greater.

*Conclusion.*—The only satisfactory treatment of chronic retroversion of the uterus fixed by adhesions, whether the uterus be pregnant or not, is to free the adhesions by the abdominal route and to suspend the uterus. The prognosis, both immediate and remote, is excellent.

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DR. SPENCER SHEILL said he did not think that all the operations were equally satisfactory. He admitted that they were satisfactory if done in a satisfactory manner, as each

case had its own indications. The choice of the case was of importance. All cases with which he had to deal were capable of being replaced, but in a case of markedly adherent uterus he would certainly agree that laparotomy was necessary, but he did not agree that ventral suspension should follow because the amount of irritation produced by suturing was likely to bring about abortion. As far as the operation of suspension was concerned, they all knew that a new adhesion formed by suspension would stretch in pregnancy and become a ligament, and he, therefore, failed to see the good of ventral suspension in such cases. He would sooner let the patient go to the end of pregnancy and give the matter attention at that time by the insertion of a pessary as soon as it was considered safe to do so.

DR. GIBBON FITZGIBBON said that the matter of drainage in the case of pus tubes being met with was a difficult point to decide. He always felt that by fixing the fundus of the uterus, and then draining the pelvis through the lower angle of the wound, one ran the risk of making the suspension into a fixation, and in these cases, therefore, he thought there was a distinct reason for selecting the Gilliam operation; then, if adhesions were produced they would not cause fixation in the same way as if the uterus was fastened to the peritoneum. He preferred drainage through the abdomen where there was any real necessity for drainage. He had followed up several cases of pregnancy after ventral suspension had been done, and he had never found that they had any difficulty in pregnancy or delivery, but he had found that in some of the cases retroversion recurred three or four weeks after delivery, but this was easily cured by replacement and retention in place by a pessary for six or eight weeks, and then remained in place without any further treatment.

DR. MADILL said he did not think all cases of fixed uterus required operation at all. Most cases that he had seen operated on in Berlin were done by the vagina, and there was no doubt that this method prevented the handling of the intestines, but he thought the abdominal route was preferable. He suggested that these cases were all due to infection, and if any intra-peritoneal fluid could be obtained a culture should be taken. An adequate pelvic floor was

essential in any operation for retroversion, and if not present should be made. When the uterus was brought forward out of the retroverted position he considered that the strain was too much to be suspended straight away, and thought a pessary should be worn for a couple of months.

DR. E. H. TWEEEDY said he thought Dr. Solomons had well described the modern method of treating retroversion. He had never heard of pregnancy in a retroverted uterus being liable to cause rupture of the intestines, and he asked Dr. Solomons to quote his authority for such a statement. Abortion was not unavoidable even in a fixed retroverted uterus, and he therefore thought it was a serious step to open the abdomen in such cases whilst the woman was pregnant. The word "criminal" was entirely too strong to apply to the conduct of a man who refused to operate. He asked if any one present had known of a case where a pregnant woman died from rupture due to fixed retroversion. If there was an infected area, peritoneal adhesions formed round the gauze and shut off the peritoneal cavity, and when the gauze was withdrawn it formed a channel by which the septic discharge would come away.

He was satisfied that the results were good in ventral suspension, and he had never seen any difficulty in delivery after it. The suggestion that the ligament stretched and would not contract seemed to him outside the question. His object was to fix the fundus of the uterus to the bladder, and by that means he obtained an absolutely mobile uterus which was free from danger in pregnancy and delivery. When he heard of relapse after ventral suspension he knew the operation had not been properly performed.

DR. M'ALLISTER said the exact position and shape of the backwardly displaced uterus was of importance when such a uterus became pregnant. A pregnant uterus which was not only retroverted, but also markedly retroflexed, would even in the absence of adhesions have very little chance of righting itself spontaneously. He agreed with Dr. Madill that there were old-standing cases of fixed retroversion which were symptomless. He was sceptical about the statement that all cases of acquired retroversion were complicated by some degree of prolapse. Appendicitic inflammation could, he



thought, drag the uterus backwards without any uterine descent occurring. The presence or absence of uterine descent would guide him, amongst other things, in his selection of an operation for restoring the uterus to its proper position. The Alexander-Adams operation did not lift the uterus to any great extent. It merely drew it forwards. He always ended up these cases by doing this operation provided there seemed to be no reason for attaching the uterus higher up on the abdominal wall. The disadvantage of suspension operations was that, owing to the traumatism of the peritoneum, apart from the question of sepsis, a considerably broader attachment to the uterus might occur than had been intended. Were the uterus very large he would excise portion of its anterior wall. He referred to Pestalozza's operation. Were the tubes distended with pus and the infection gonorrhœal, he would remove the uterus with the appendages.

THE PRESIDENT said that these cases of chronic fixed retroversion were always due to infection, and there are no symptoms which can be associated with the malposition alone. Symptoms which can be attributed to the pelvis are due to the persistence of the pelvic inflammation or to the adhesions. Pain rarely exists if a sufficient interval has elapsed since the infection occurred. The fixation of the uterus and adnexæ may cause dyspareunia and difficulty or pain during defæcation, but the most usual causes of complaint are sterility or abortion. In the management of these cases the nature of the infection must be ascertained if possible. The relief of fixation of the uterus and adnexæ should be considered only when any of the symptoms already mentioned are present. Laparotomy should be performed. After the adhesions are divided and salpingostomy in cases of sterility, the round ligaments should be shortened. When symptoms due to the inflammatory condition persist or recur after a sufficient interval from the time of infection in spite of thorough expectant treatment, as is most likely in gonorrhœal cases only, removal of the uterus, tubes, and ovaries gives the best results. Removal of the tubes and cure of the malposition rarely give permanent relief in these cases.

DR. SOLOMONS, replying, said he recalled a case which he

had met recently which was a most striking contradiction to the remark that symptoms were seldom met with in fixed retroversion. In this case the patient had been bleeding profusely for a fortnight, and this was her only symptom. Fixed retroversion with tubal disease was diagnosed. In separating adhesions pus exuded which on examination was found to be sterile. The appendix was also involved in this case. He made it a rule if any pus could be obtained to take it for examination. He always followed Dr. Tweedy's teaching never to operate on fixed retroversion if there were no symptoms, but it seldom happened that patients consulted him if they had no symptoms. One should choose the operation which best suited the case, and the one chosen should be done perfectly. He had not seen any case of fixed retroversion in which the uterus was so big that it would have been in any way improved by performing utriculoplasty, thus making a simple operation a serious one. The statistics of cases of operation for displacement were rather elusive, as patients were usually examined within a year afterwards, and it seemed to him that for statistical purposes patients should be examined after a longer period in order to form any conclusion of value. He did not agree with those who said that when a ventral suspension was performed it went back afterwards. It did not go back unless the operation was badly performed. Referring to the suggestion that instead of doing a ventral suspension after separating the adhesions in the pregnant case reported, a pessary should have been inserted, he said that pessaries sometimes slipped, and he did not wish to run any risk in this case.

He thought that drainage, either vaginally or abdominally, was good. The idea of using gauze was, of course, to cut off the infected area. It seemed to him that where there was a fixed retroversion there was always endometritis, and that was the reason that he thought curettage should be done as well as some suspension operation. He did not agree that a post-operative pessary was necessary where the operation for retroversion was effectively performed. He had done several cases of shortening of the round ligaments according to the Alexander-Adams method after the performance of treatment in the abdomen.