

artery forceps and pulled outside the wound, and the forceps dropped in the abdomen. This insures enough peritoneum remaining after the suspension of the uterus to allow the perfect closure of the abdominal wound, otherwise the sutures used to suspend the uterus tend to rob this part of the wall of its peritoneum.

The finger then glides down behind the symphysis over the top of the bladder on to the anterior face of the retroflexed uterus, which is hooked up and drawn forward into ante flexion. Two sutures of medium sized silk are used for the suspension.

The abdominal wall on the left side of the incision is hooked up by two fingers until its peritoneal surface is exposed within for an inch. Then with a small, stout, curved needle the suture is passed so as to grasp about one-quarter of an inch of the peritoneum, and some of the fibers of the rectus muscle. The fundus uteri lying behind the symphysis is exposed by crowding the intestines back with fingers, retractors or sponges on stalks, the needle is then boldly passed through a portion of the posterior surface of the uterus below the fundus, about the same amount of uterus being included as that taken up on the abdominal wall; the suture is then drawn through, and finally the peritoneum and a part of the rectus are caught as on the opposite side of the incision. The suture is drawn taut and at once brings the uterus snugly up in slight ante flexion to the abdominal wall and at the same time approximates the three peritoneal surfaces (uterus, and abdominal wall on both sides) transfixed by the suture; the suture is then tied and a second, which is introduced with greater facility than the first, transfixes the uterine tissue a little below the first, and thus when it is drawn up to be tied, lifts the uterus a little farther into ante flexion. When the sutures are both tied, the finger is introduced into the abdominal cavity and a careful examination is made to see that the intestines and omentum have not been caught at any point above or in front of the uterus. The peritoneum and the abdominal wound are closed in the same manner as after an ordinary cœliotomy. The uterus is thus suspended in ante flexion to the anterior abdominal wall by two buried silk sutures. A few weeks later the uterus is found upon vaginal examination to be in a position of easy mobile ante flexion, without any apparent connection with the anterior abdominal wall.

I have taken for criticism in this connection all my cases operated upon by any abdominal operation in the Johns Hopkins hospital, not including those performed since the first of the year. Out of eighty cases referred from the dispensary by my assistants and from private practice by myself, forty-four were found suitable for operative treatment.

Forty-seven operations were performed; three cases requiring a second operation. Twenty-eight were married women; sixteen were single; twenty-eight had borne children and averaged about three each.

There were no deaths, and as far as I have been able to learn, no discomforts arising from the operation.

A simple suspensory operation was performed in twenty-three cases. Other operations were performed at the same sitting in twenty-one cases.

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## SURGICAL TREATMENT OF UTERINE FLEXIONS.

Read in the Section of Obstetrics and Diseases of Women, at the Forty-fourth Annual Meeting of the American Medical Association.

BY M. B. WARD, M.D.

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It is my desire to briefly consider the propriety of doing an abdominal section, in suitable cases, for retro-displacements of the uterus.

It is, perhaps, unnecessary that I should preface my remarks with the statement that he who dares to recommend such radical measures for an ailment so insignificant in character, is certain to be severely criticized, and perhaps charged as having an unnatural desire to use the knife when milder measures meet all the indications. It is better, however, to give our views in our own way, from our own standpoint, and cultivate that generous spirit which allows others to do the same.

In my experience, it has been extremely difficult and very often impossible to afford permanent relief in a large majority of cases of chronic retroflexion, by methods usually recommended. It is comparatively easy to give temporary relief in many cases, if we will persistently treat the patient by placing her in the knee-chest position, and gently raise the fundus and tampon the posterior vault with cotton wool, saturated with boro-glycerine. I refer to this method because I consider it a good, if not the best plan of treatment. When it is impossible to replace the uterus in the normal position on account of adhesions, this treatment softens the adhesions, relieves engorgement and gives comfort. But the larger number of our patrons will give histories of long suffering, many attacks of pelvic peritonitis—some mild, and some severe—which will readily indicate that serious complications must be overcome before the uterus can be brought forward to the normal position. It is this class of cases that I am considering in this essay.

What shall we recommend as the best plan of treatment? My custom is to say to the patient that the local treatment will give comfort and, if she can exercise due patience, she *may be* permanently relieved. I always inform them of the possibility of failure. The next plan recommended is to do an abdominal section, break up the adhesions, remove the appendages—if they are diseased, bring the uterus forward and close the abdomen, all of which may be done in a few minutes safely—and your patient will speedily and permanently recover. I am again anticipating unfavorable criticism on account of the apparent unconcern which I manifest toward those much talked about little organs—the ovaries. I do not wish to be understood as one who ignores the right inherent in every woman to possess these, as well as all other organs which of right belong to her; but I do wish to be placed in that class who throw aside sentimentality and treat conditions in a common sense and scientific manner. When surgical measures are indicated as the only source of relief, we should not refuse to employ them, even though it may be found necessary to remove organs adjacent to the uterus. Let me explain still more fully my views on this subject. Many times an operation by section for retroflexion may be successfully performed without the necessity of removing the appendages, but it will be necessary in these

cases to take extra precaution against a recurrence by fixing the uterus in its normal position, by shortening the round ligaments, or by ventral fixation. I should not by any means remove healthy ovaries when operating for retroflexion by the section method. Should I find the ovaries diseased, then I would not hesitate to remove them. There is a proviso, however, that I wish to insert in this connection, namely: when the patient is young and would naturally wish to bear children, I should not then remove the ovaries, unless they were so altered by disease as to make fecundation impossible. In view of the fact that it is not always easy to define the extent of the destruction of normal ovarian stroma, we should give the would-be mother the benefit of all doubt and leave undisturbed the suspicious ovary. On the other hand, should the patient be the mother of several children—and there is no reason why she should have more children, unless she herself desires them, I should not be so particular to give the suspicious ovary a chance to assert its normal function, if to remove it would promise great relief to the sufferer.

From my no inconsiderable experience, I am prepared to make the statement, that it is only occasionally necessary to make the fine distinction before mentioned, for in nearly all cases of chronic retrodisplacements, the appendages are seriously involved and therefore diseased beyond any question.

The most satisfactory feature of the operation now under consideration, is the fact, almost universal, that the uterus will remain permanently in the anterior position without support, if the appendages are removed. It is surprising how emphatically nature asserts herself when the *guy ropes* are cut which hold the uterus in abnormal position. Immediately the uterus will go forward—almost with a bound—and reminds one of a sapling that has been bent to the ground and held, but which quickly returns to the upright position as soon as the force which binds it down is removed. So charming are the results of this operation in cases where the patient has suffered greatly for years, and has been subjected to all sorts of methods of treatment, and without permanent relief, until she has formed unfavorable opinions of the profession, that he who relieves her by this method is classed, and justly too, with the greatest of benefactors.

The next objection to this method, which I anticipate will be advanced is, that the danger to life is too great to operate in the abdomen for a condition which does not, of itself, destroy life, but only causes suffering and perhaps may do permanent harm only by establishing nervous sequelæ; this is the most important question to be considered in this connection. If it is a fact that the operation recommended is to result fatally, then of necessity we should only perform it as a dernier resort. But I contend that this operation should not give any greater mortality rate in properly selected cases than would amputation of a finger in properly selected cases. What I call properly selected cases, are those who have the endurance which will justify us in doing any kind of surgical operation of sufficient magnitude that complete anæsthesia and confinement in bed for two or three weeks would necessitate. That there is a degree of danger in any operation goes without saying and, therefore, it would be a mistake to assure the patient and friends that there

is not some danger in this method; but it could be said with propriety that in the uncomplicated cases the mortality is about nil. Not more than 2 per cent. should perish. It is customary to fortify one's statements, when treating of a subject of this character by reporting cases, and I should gladly do so on this occasion, except for the reason that it is entirely unnecessary in view of the extensive experience of all present. Suffice it to say that there are a goodly number of ladies in my State who would gladly make testimony touching the renewed health—almost renewed life—they are enjoying; the result of this operation. No death has occurred to dampen my ardor, but I am always and at all times looking out for possible complications, by stating to the patient and friends that something may occur, and am on my guard, expecting something to occur that would cause all to grieve.

It is possible that I should have occupied more of the valuable time of this Section by a more detailed and elaborate classification of cases that should be subjected to abdominal section for the cure of displacements of the uterus; but I am obliged to leave to the generosity of my confrères to give the essayist the benefit of the doubt—as we would say in law—and convict him by trial before pronouncing judgment. In other words, I am not anxious to operate in the abdomen, if other methods less dangerous can be employed with good results.

## PROLAPSE OF THE FEMALE PELVIC ORGANS.

Read in the Section of Obstetrics and Diseases of Women at the Forty-fourth Annual Meeting of the American Medical Association.

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It is my desire to call attention, briefly, to prolapse of the female genital organs, with particular reference to their hernial nature; regarding them as having a similar etiology, and the same pathological significance as herniæ in other situations, and amenable to analogous lines of treatment.

The classic division of herniæ into cephalic, thoracic and abdominal is incomplete without the important group comprised in the title of this paper; and, in view of their frequency and importance, they should enjoy an individual classification in herniology.

For accuracy and convenience, we would designate four major classes; cephalic, thoracic, abdominal and pelvic herniæ.

The etiology of these affections, in general, comprises such predisposing and exciting causes as defective development, including congenital malformations and inherited tendencies; depraved muscular tone through debilitating disease, and trauma.

While the majority of cases are generally attributed to traumatism, this may often in itself be the result of defective development, and inherited or acquired weaknesses or malformations.

Again, defective development represents not only the malformations of foetal life, but the results of arrested growth at the period of ripening or puberty.