

retary, Dr. Charles H. Shepard, and to all the members who kindly responded to our invitation to read papers, which you will note by referring to the titles and authors in the program, are of unusual scientific interest.

ORIGINAL ARTICLES.

NOTES ON TWO CASES OF PELVIC SURGERY.

Read in the Section on Obstetrics and Diseases of Women, at the Forty-sixth Annual Meeting of the American Medical Association, at Baltimore, Md., May 7-10, 1895.

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These cases I report, as throwing some light on the philosophy of ventrofixation:

Case 1.—Mrs. K., age 46, married twenty years; 2-para; youngest child 18 years of age. Seen first in June, 1892. Complained of menorrhagia. Five curettements had been done without much, if any, benefit. Perineum had been attempted by Tait's method which had not given satisfaction. In fact, there was yet a pronounced flatus vaginalis. The first thing I did for the patient was to curette the uterus carefully and pack it with iodoform gauze, and at the same time do an Emmet operation to repair the pelvic floor. The latter was a happy success, in so far as it restored the function of the pelvic floor, but this statement may be questioned, when I admit that it did not raise the uterus as high as its normal place, nor change it from its position in the second degree of retroversion.

Within three months the menorrhagia was bad as ever, and following the menstrual periods there would be a mucoserous discharge so irritating in its character as to abrade the cutaneous surface of the labia and thighs and render the patient hyperesthetic.

Another time I used, I think quite thoroughly, the curette; very little if any improvement took place, and when three months had passed I again curetted somewhat vigorously, and yet no considerable change of the condition was effected. The bimanual examination showed the uterus to be of about normal size and the uterine sound added confidence to this belief.

For more than a year, patient was treated expectantly. In May, 1894, on examining the first time for six months, a tumor the size of a Tangerine orange was found at either side of the uterus, and patient was complaining of constant pain. Within a few days celiotomy was done, and the two cysts, ovarian, were removed, and ventrofixation of the uterus was done also. Convalescence was without remarkable event and my patient improved to an extent, as to say, she underwent a precipitate menopause and not suffering her accustomed waste of blood, began to improve in strength and general appearance.

But still there remained a doggedly persisting uterine discharge—muco-serous in character—which was so irritating to the woman, using her own language, as to render life a misery to her. The irritation, so to speak, was exquisite. It set up a nervous erythism which she felt at times was unbearable.

In November, 1894, I removed the uterus on account of this uterine discharge for which I had tried every other remedy that I could think might be of benefit. On account of the former celiotomy and ventrofixation, I decided to remove the uterus by the suprapubic method, and did a total extirpation. Just before operating, I made a digital examination *per vaginam*, and while the uterus was found to be in good position it was so movable that I supposed it was no longer in any way connected with the abdominal wall. On opening the abdomen, the uterus was found suspended from the abdominal wall by a ligamentous structure about an inch in length by an inch in width, bearing a close resemblance to the natural uterine supports, consisting of two layers between which were the sutures. Recovery, as in the former instance, was perfectly smooth and patient is very well.

Case 2.—Mrs. R., age 39, 2-para. Had secondary syphilis, cyst of broad ligament, lacerated cervix, endometritis, retroversion of uterus and ruptured perineum. As she was a county charge and the officials being highly esteemed for their "political economy," I felt that I should do all I could for her at one sitting, for it was quite certain that she would not again have the chance to enter the hospital for surgical

treatment at the county's expense. Accordingly, and as rapidly as possible, and yet it required about an hour and a half, I curetted the uterus, repaired the cervix and perineum, ligated the hemorrhoids after stretching the sphincter ani, opened the abdomen after carefully cleansing the hands, cared for the cyst of the broad ligament and did ventrofixation of the uterus also.

The convalescence was easy; the results were satisfactory.

In the early part of February of this year she visited me at the Portland Free Dispensary to say that she had not menstruated for three months. Examining her, I was convinced that she was pregnant between three and four months. I would like to remark just here that patient had been examined each month at the dispensary and the uterus had been found in good position and movable. I impressed upon her mind the importance of being seen frequently, and accordingly she has come to the clinic every week. About the first of March she had some pain at the point of ventrofixation. This troubled her but slightly for three weeks and ended. She seems to be passing along through her gestation naturally. I think she is pregnant about six and a half months, and have hopes that she may go on to full term smoothly. We are keeping her on 10 grain doses of potassium iodid three times daily.

In conclusion, I feel like stating that I have never been better pleased with the results of any of my gynecologic operations than those of ventrofixation. I believe that it is just as valuable for extreme anterior displacements as for the posterior variety; yet it might not be appropriate to do it more than once perhaps for the former while it is being done twenty times or more for the latter, for the reason that cases demanding it for anteversion or antelexion are relatively so infrequent as compared to those demanding it for posterior displacements. In other words, cases of extreme anterior displacement are rare.

I now know of three prominent and highly qualified surgeons who have employed this means of suspending extremely anteverted and antelexed uteri, during the past year, and they have reported satisfactory results.

Last year at San Francisco, I read a paper before this Section on ventrofixation for extreme anterior displacements of the uterus, reporting six cases so operated on with pleasing results. Since that time I have met with but one case of the kind sufficiently bad to require the operation, while during the year I have suspended the uterus perhaps a dozen times for retroversion. To be sure, retroversion is usually accompanied with some degree of decensus, which is the cause in part at least, of the attending symptoms, but I am not convinced that anterior displacements do not cause bladder and menstrual disturbances equally great in rare but occasional cases.

When I read my paper in San Francisco I was as well as now aware of the popular professional opinion regarding the clinical import of anteversion and antelexion, and yet, results of the few operations that I reported were so satisfactory, as well as encouraging reports from others who have done the operation, that I am still under the persuasion that the procedure is one of value. While it is so absolutely safe, barring the possibility of accident or error, I presume its justifiability will hinge upon the question, Is there such a thing as pathologic ante-displacement of sufficient consequence to merit attention or treatment? If so, the operation which I have proposed deserves your consideration and trial; if not, I am laboring

under a mistake; a part of Dr. J. Marion Sims' valuable time was wasted, and Dr. Dudley, of Chicago, has perpetrated a joke upon himself.

If it be not asking too great a favor, I should be glad if those who believe in the existing importance of ante-displacements, would give this simple and safe operation a single trial.

While the immediate effect of the procedure suggests the term, ventrofixation, in view of that which takes place secondarily, I am willing to accept the name which Professor Kelly now is using as a better one, and certainly he has the right to christen his own child.

DISCUSSION.

DR. A. LAPHORN SMITH, of Montreal—said he was very much indebted to Dr. Kelly for this operation, which he has now performed twenty-six times without any mortality rate and with very gratifying results. He referred to the importance of scarifying the peritoneum and anterior surface of the uterus for the purpose of favoring adhesion. He employs a permanent sterilized silk ligature in stitching the uterus to the abdominal wall. The organ is quite movable after the operation. He considers it preferable to Alexander's operation. He had done the Alexander operation twenty-six times before he began this method.

DR. REUBEN PETERSON, of Grand Rapids—said the first operation that he attempted for suspension of the uterus by the ovarian ligament was devised by Dr. Kelly. Dr. Kelly was fortunate in getting a large number of cases upon which the operation could be done, and we must depend upon the record and the results of a large number of cases in order to determine the special method we shall adopt. In seventeen cases he has suspended the uterus by means of the ovarian ligament. Recently he had the opportunity of examining ten of the patients personally, and had a report of five others. In ten of the cases the anatomic result was perfect, and a cure has been effected in fifteen out of the seventeen cases.

DR. RUFUS B. HALL, of Cincinnati—thanked Dr. Kelly for his excellent work in this direction, and said he had made the operation a number of times and was very much pleased with it. He mentioned the fact that in a number of cases in which one ovary was removed and the uterus fixed to the anterior abdominal wall, the patients had borne children without inconvenience. One patient complained of considerable pain in the line of incision about the fifth or sixth month, after which she went along and was delivered without trouble. He is more and more convinced that time will prove that retroversion will be treated in this manner as a routine mode of treatment.

DR. J. HENRY CARSTENS, of Detroit—said that ordinary cases of retroversion of the uterus without any adhesions did not require ventral fixation. He believes that such cases can be treated by mechanical means. Some of these women do not complain of any symptoms whatever, while in other cases more or less pain and distress are complained of. He finds also in these cases of retroversion of the uterus that a diseased tube is generally at the bottom of the whole trouble, and as a result we have on one side the tube, ovary, uterus, and rectum matted together. In such cases we have to perform abdominal section and remove both the diseased ovary and tube. When we do that and break up the adhesions between the uterus and rectum, we may as well stitch the stump in the lower angle of the wound and keep the uterus anchored *in situ*, while the other side being perfectly healthy will go on and functionate and the woman may become pregnant. He claimed that all cases requiring ventral fixation are due to a diseased tube and ovary, and they must be removed in order to do any good. He was perfectly astonished in the light of modern surgery to hear that Dr. Kelly still employed silk for ligatures in these cases, and thought it would be better to employ some absorbable material for that purpose.

DR. BEVERLY MACMONAGLE, of San Francisco—has performed the operation a number of times with excellent results. With regard to scarifying the tissues, he does not think this is necessary if the sutures are passed as recommended by Dr. Kelly. The whole intra-abdominal pressure is on the back of the uterus, and while the tissue allows it to sink down it does not permit the abdominal viscera to come between the uterus and abdominal wall. He has had quite a number of patients who have declined the operation. The operation of vaginal fixation is coming forward and

being practiced by a neighbor of his very generally, and he was anxious to hear the different opinions on this subject.

DR. M. B. WARD, of Topeka, Kan.—felt certain that there was no operation in surgery that is equal in its results to the one described by Dr. Kelly. He does not agree with Dr. Carstens as regards the benefit of mechanical treatment in these cases. A gynecologist might treat a uterus for six years by trying to replace it by mechanical methods, and yet eventually would be forced to do this operation in order to effect a cure, and if Dr. Carstens could replace a uterus in these cases by manipulation with tampons and pessaries, he was more skillful than the speaker. He had had excellent results in cases of ventrofixation.

DR. G. R. FEIL, of Cleveland, Ohio—referred to a case in which fatal secondary hemorrhage followed the performance of the operation. The patient was a woman, 33 years of age, upon whom a double ovariectomy had been performed. The uterus was retroflexed, and the physician in charge performed the operation as recommended by Dr. Kelly.

DR. X. O. WERDER, of Pittsburg—was sorry that vaginal fixation was not more discussed than it had been. He saw Dr. Kelly do his operation of suspensio-uteri two years ago, and was well pleased with the method and had been using it until seven or eight months ago. He had operated twenty-five times by Dr. Kelly's method and his results had been very good until he encountered mural abscesses. Shortly after this he noticed that German operators were recommending vaginal fixation. He has resorted to this method in thirteen cases. One advantage of vaginal fixation over the abdominal method is the avoidance of the abdominal incision, and he knows from experience that with many patients this is an important matter. Many patients will submit to vaginal fixation in connection with a cervix operation, Emmet's perineal operation, or some plastic operation about the vagina when they will flatly refuse to have the abdomen opened for correcting a malposition of the uterus. Another advantage of vaginal fixation is that patients can leave bed in ten days. After the operation they do not complain of any pain, thirst, or any of the disagreeable symptoms that are frequently complained of after an abdominal section.

CONCERNING THE PRINCIPLES AND PRACTICE OF EPISIOTOMY.

Read in the Section on Obstetrics and Diseases of Women at the Forty-sixth Annual Meeting of the American Medical Association, at Baltimore, Md., May 7-10, 1895.

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Nature teaches that she endeavors to establish a favorable relativity in size, axes and diameters between those of the mother and her parts, especially the pelvis, and those of the fetus and its parts. Where this is, there is the normal. When this favorable relativity is present and with long fetal part diameter to long pelvic diameter given the proper parturient power, there will be natural, unassisted or normal labor, without destruction or harmful adaptation of part to part; where otherwise, as long fetal part diameter to a shorter pelvic diameter there will be unnatural or abnormal labor, requiring corrective assistance either natural or artificial, be it at the superior strait, in the cavity or at the outlet; be it upon the mother's part or upon the fetus' parts, and as a result of such deviation, necessity has invented operations, such as the forceps, turning, Cæsarean section, embryotomy, and yielding for a moment to the symphyophile, symphysiotomy. At the outlet, nature teaches episiotomy. At the outlet, the longest diameter is the antero-posterior, and to it must be apposed, and through it must pass the longest diameter of the fetal part, and this is usually the case. Unfortunately the antero-posterior diameters of the osseous and soft pelvic outlets are not equal in length, that of the soft outlet being shorter, so that often a fetal part will readily clear the osseous outlet, but