

## A Case of Chronic Inversion of the Uterus of Puerperal Origin.

By EWEN J. MACLEAN, M.D., C.M. (Edin), M.R.C.P. (Lond.), F.R.S.E.,  
*Senior Gynæcologist, Cardiff Infirmary; Consulting Gynæcologist, Porth and Mountain Ash Cottage Hospitals, etc.*

A. L., æt. 29, a married woman, was sent to the gynæcological department of the Cardiff Infirmary, in December, 1905, by Dr. E. W. S. Martin, of Brithdir, whom she had consulted for repeated and copious hæmorrhages following on her last confinement, which latter had occurred two and a half months previously, and in which she had been attended by an unskilled midwife. The patient had had three or four miscarriages and five full-time normal confinements.

At the last labour, however, the placenta had been retained, and there is reason to believe that a considerable degree of traction was applied to the cord. As a result of this and other manipulations, the secundines were eventually delivered, and immediately thereafter a very free post partum hæmorrhage occurred accompanied with some amount of collapse and local pelvic pain. The patient rallied, and the blood loss, which was present and which continued in varying amount, appears to have been regarded as only an unduly prolonged and free lochial discharge. In other words, the local condition had been uninvestigated and unrecognised until medical advice was sought. The patient was then sent to me by Dr. Martin.

On admission the profound anæmia was very noticeable, as also were the marked debility and weakness. The pulse was soft and compressible, though not more frequent than 80 per minute. The temperature was 98°, and the urine normal. Per abdomen, nothing noteworthy was made out. Per vaginam, the passage was found to be occupied by a smooth, elastic, pear-shaped swelling of deep-red colour, about two and three-quarter inches in length, its broader and lower end being about one inch and three-quarters in diameter. The narrower stalk of the tumour sprang from the antero-superior wall of the vagina, and presented a slightly elevated collar-like rim in its circumference at the level where it became continuous with the vaginal walls. There was no opening into which a sound could be passed to represent the uterine cavity.

Bimanually, nothing corresponding to the body of the uterus was appreciable in the pelvic cavity, and a cup-like depression was felt leading to the vaginal tumour.

From the history, symptoms, and physical signs presented by the case, no difficulty was experienced in arriving at the *diagnosis* of inversion of the uterus of puerperal origin.

The everted mucosa of the uterus, though not ulcerated, was soft, and even the gentlest handling in examination induced considerable hæmorrhage. This tendency indicated the adoption of a line of *treatment* which should be as promptly effective as possible; accordingly, on the day after admission, the patient being prepared for operation either by the vaginal or abdominal route, she was deeply anæsthetised. Steady centripetal pressure was applied to the uterus by the hand in the vagina, and this somewhat diminished its bulk. Ordinary bimanual pressure and counter-pressure proving ineffective, a volsella was fixed both anteriorly and posteriorly in the middle line at the level of the rim which represented the junction of the cervical and vaginal lining membranes. Pressure applied evenly as against these two fixed points caused a further demarcation of the rim. This became sufficiently marked to allow of the affixing of the four volsellæ at equal intervals apart, on the now easily recognizable cervical lips. The volsellæ thus placed being held by assistants, I was able to exert, without any considerable risk of laceration, a steady and forcible pressure with the thumbs over the fundus and the remaining fingers of both hands effectively supporting the lateral walls of the uterus. In the course of a few minutes the uterus was slowly and completely re-inverted. The cavity was then freely douched with hot iodine lotion, and iodised phenol was applied to the interior. Thereafter a tight pack of sterilised gauze was inserted to prevent any tendency to recurrence of the inversion, and for the same reason a silk-worm gut suture was applied at either angle of the now very patulous and flaccid os uteri.

The patient made an uninterrupted recovery.

#### *Remarks.*

The qualification "chronic," as applied in the case here described, is used in the sense suggested by Ovi in his paper recorded in the *Annales de gynéc. et d'obstét.*, October, 1901, where the term is employed to indicate that the condition of inversion is present at a time subsequent to labour later than the date when it is usual for the catamenia to return.

No comment is needed as to the probable causation of the condi-

tion beyond the expression of the hope that the effectual operation of the Midwives Act will shortly render so unduly delayed a recognition of a grave departure from the normal an impossibility.

The *diagnosis* was unmistakable. It was of much interest to note the extent to which involution of the uterus had advanced in ten weeks notwithstanding the inversion.

As to *treatment*, I have never used a repositor, and the readiness with which bleeding ensued on making examination seemed to me a contra-indication, and its employment would probably have involved harmful delay.

Amputation was out of the question, as there was no local sepsis, sloughing, or ulceration.

The desideratum was reduction at one sitting under anæsthesia, and had the taxis measures which are recorded above proved unavailing I intended to open the abdomen and to divide the "cup" posteriorly, from the peritoneal aspect, as deeply as might be required for the reposition by bimanual manipulation, a method I have seen adopted with signal success. This is probably a safer method than those in which a corresponding division is effected from the vagina through an opening in the anterior or posterior fornix. The field of operation is under more complete control for suturing and hæmostasis after the reposition, and for the purpose of effecting the reposition the counter-pressure from above may be more conveniently and accurately applied.

This additional instance of the successful application of taxis in chronic inversion suggests that in like cases the method should be given a fair trial before resort is had to anterior or posterior colpo-hysterotomy or to abdominal section.