

A New Method of Performing Ventri-Suspension of the Uterus.

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VARIOUS methods have been described whereby the uterus may be fixed to or suspended from the anterior abdominal wall for retro-deviations. I make bold to add another to the number. It embraces, I think, all the good points of the operations previously described, while it does away with their disadvantages and dangers. In this operation it will be seen that there is no possibility of any bowel becoming strangulated, nor is there any interference with or hampering of the bladder. It is very effectual and suspends the uterus in a more natural position than any operation previously described. It is easily performed, and the patient does not complain of any pain or inconvenience after.

An opening is made through the anterior abdominal wall sufficiently large to permit of a thorough inspection of the contents of the pelvis. A self-retaining retractor is placed in the upper part of the wound, the handles pointing upwards. The displaced uterus is raised, and any adhesions present are broken down. The ovaries are then inspected and if any abnormality be noticed, it is attended to. The round ligaments are next defined and followed outwards to where they enter the abdominal wall. Beginning at the point where the left round ligament enters the abdominal wall, with good strong catgut—not too thick—in a curved needle, I stitch the ligament to a fold of peritoneum and carry this on as a continuous suture embracing the round ligament and stitching it to the parietal peritoneum till the uterus is reached. At this point this suture is tied. Then with another catgut suture and curved needle the right round ligament is taken up where it leaves the abdominal cavity, and a continuous suture carried along in the same way as on the other side till the uterus is reached, and then the suture is carried along the front of the uterus suturing it also to the peritoneum till the first suture is reached. In the process of stitching, the round ligaments, which are usually found lengthened and thinned out, are shortened. The abdomen is then carefully closed in separate layers by continuous catgut sutures.

I have now performed this operation several times, and am well satisfied with it. I have examined patients after they have been going about for some time, and the position of the uterus is really

excellent. There is no trouble whatever with the bladder. The first time it suggested itself to me was in the case of a young nulliparous married woman, whose abdomen I opened to rectify a bad retro-flexion. I had intended performing the operation of suspension after the method of Sir William J. Sinclair. On opening the abdomen, however, I found that the appendix vermiformis was attached by its tip to a loop of small bowel which was also bound down in the pelvis. To get properly at this I had to enlarge my abdominal incision. After removal of the appendix, which was diseased, freeing the bowel and cleaning up, I turned my attention to the uterus. Its anterior surface, which had been turned round and wedged down in the pelvis, did not look at all inviting to stitch to the peritoneum, so the method described above was followed. The patient left the hospital in three weeks feeling quite well.