Clinical lecture on the flexions of the uterus : with a report of the ovarian and other diseases admitted into Prudhoe Ward, Middlesex Hospital, in the year ending July, 1864 / by John Hall Davis.

FLEXIONS OF THE UTERUS

DR. DAVIS.

CLINICAL LECTURE

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WITH A REPORT

OF

THE OVARIAN AND OTHER DISEASES ADMITTED INTO PRUDHOE WARD, MIDDLESEX HOSPITAL, IN THE YEAR ENDING JULY, 1864.

BY

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CLINICAL LECTURE

ON THE

FLEXIONS OF THE UTERUS.

GENTLEMEN,—Among the various Displacements of the Uterus, we must rank next in order of frequency to the different degrees of descent which we have already considered, the flexion of the organ.

The term flexion is applied to two varieties of that displacement—viz. Anteflexion and Retroflexion, the body of the uterus being bent upon the cervix in a direction *backwards* in the latter, *forwards* in the former, and at an angle more or less obtuse, while the axis of the neck remains unaltered.

Within the last twelve months there have appeared among the in and the out patients of this hospital several cases of retroflexion, whereas instances of anteflexion have rarely come under our observation; and similar has been my experience in other opportunities which have occurred to me.

This difference in the comparative frequency of the two flexions, which accords with the general experience

of observers in this country,* may be intelligibly explained as follows,—that while the pouch of the peritoneum, lying between the rectum and vagina, affords a ready reception posteriorly for the displaced fundus and body of the uterus in retroflexion, no corresponding space exists in front of the organ to favour the frequent occurrence of anteflexion.

It would appear, moreover, that pressure brought to bear upon the outer surface of the uterus during various efforts, by the contraction of the abdominal muscles would tend, in the absence of any counteracting pressure, to force the fundus backwards, rather than forwards. Now, should the bladder be distended at the time of such efforts, or should a fall or a blow concur with a collection of urine in that organ, retroflexion would be the more probable displacement to happen, of the two varieties.

We have next to observe upon the particular spot at which the flexion takes place, as important to be borne in mind; for it is found to be the same in all cases — namely, opposite to the internal os uteri. Now this we know to be the thinnest part of the uterine wall, therefore the weakest point; moreover it corresponds also to the line of reflexion of the peritoneum from the bladder to the uterus. Upon this and other anatomical arrangements in this situation

* It is right, however, to notice that Rokitansky, Dubois, and some other continental pathologists, on the contrary, affirm anteflexion to be the more frequent: while Valleix and Mayer assign nearly an equal frequency to each form of flexion.

does Virschow, indeed, explain the constancy of the flexion at this particular line.

He argues that while the neck of the uterus, below that peritoneal reflexion, is fixed by its attachments to the neck of the bladder, the body and fundus above it are moveable and free to yield backwards or forwards according to the direction of pressure made against it.

Retroflexion.

Let us first consider this form, which has more frequently come under our care, both in my ward and in the out-patients' department. Here, as its name implies, the uterus is flexed backwards. The fundus of the organ is displaced downwards into the peritoneal cul-de-sac situated between the rectum and vagina (illustrated by a sketch on the board).

The Causes.—Although, in common with other observers, I have occasionally met with retroflexion of the uterus in the virgin, and in some instances as a congenital malformation, attributable to a defect of development, much more frequently this displacement presents itself in the married, and in those who have borne children, than in the unmarried and childless.

Recent delivery, at full term or prematurely, predisposes to it. The relaxation of the vagina, uterus, and its ligaments, and the increased weight of the womb soon after childbirth, favour its occurrence, more especially if the patient resumes the erect posture, or exerts herself at too early a period after that event in walking, lifting, or any other effort.

The lax state of the genital organs, during or soon after a profuse menstruation, in the same manner has operated as a predisposing cause.

The pressure of tumours, and various morbid enlargements, have occasioned the malposition; also fæcal accumulations, especially when accompanied by violent straining at stool. In other instances, a distended bladder, particularly where the patient has made a sudden effort, or received a blow, or suffered a fall at the time. I have seen it as a result of an enormous pelvic abscess, which had laid bare the bone at the left iliac fossa, and extended upwards to the left kidney, in a case in which I was consulted. Early pregnancy is another predisponent cause. Indeed, any condition which increases the weight of the uterus, such, for instance, as congestion, chronic inflammation, or a fibrous tumour growing from, or imbedded in, the posterior wall of the organ.

The *symptoms* to which retroflexion gives rise, may be resolved into the *general* and the *local;* or into the functional and the physical. Sometimes no inconvenience has been felt, and the malposition has been accidentally discovered on *post mortem* inquiry, the patient having succumbed to some other disease.

The following, however, are the symptoms, as collected from many cases of the affection, no one instance of the malady placing them all before us, although some of them are pretty constantly present:—A sense of weight and pressure, of falling down of the uterus, is felt in the vaginal passage. The menstrual function is

most commonly deranged. In some cases, as we have seen, there is menorrhagia, the catamenial flow being not only profuse, but its recurrences too frequent, and often hæmorrhagic; in other instances the patient suffers from dysmenorrhœa, the attendant pains being not very unfrequently as severe as those of parturition itself. Sometimes we have observed amenorrhœa. In the intervals of the periods, leucorrhœa is generally present. Nausea, vomiting, and various dyspeptic disturbances may appear sympathetically, and hysterical symptoms, such as neuralgic pains in the head, spine, below the left mamma, and very commonly in one or other ovarian region. Of this we have had here illustrations in the out and in patient department. From the tension to which the uterine and other ligaments are exposed, the patient, moreover, complains in many cases of dragging-down pains in the groin, at the navel, and in the sacral region. In consequence of pressure exerted on the sacral plexus of nerves by the displaced fundus of the uterus, the patient sometimes is harassed by aching pains in the sacral and gluteal regions, extending down the back of the thighs, or complains of numbness in the same course; sometimes even resembling a partial paralysis of the lower extremities, disappearing on the removal of the malposition. An example of this kind presented itself to us in Prudhoe Ward, transferred to my care by Mr. De Morgan. Sometimes, from a deviation of the fundus towards one side of the pelvis, these effects of pressure are confined to the corresponding side.

Other results of pressure on the parts adjoining, are a sense of weight in the rectum, difficult defæcation, of which you have had examples ; sometimes dysuria.

The patient's local distress is much aggravated by sexual intercourse, by standing, walking, especially on uneven ground, going up and down stairs, long sitting, and by any effort, especially that of lifting.

Not unfrequently carriage exercise, even in easy-going vehicles, is intolerable ; and comparative comfort can only be secured in the recumbent posture.

When the uterus becomes heavier from congestion at each menstrual period, the patient's sufferings are then much increased. Should pregnancy exist at the time of the displacement, or should, as occasionally happens, conception take place during the presence of the malposition, abortion is very apt to follow. Yet cases do sometimes occur, as in two ladies recently under my care, in which, with advancing gestation, the uterus has spontaneously recovered its natural position, and prosperous labours have ensued.

Retroflexion of the uterus, however, more frequently proves a cause of sterility, which has been in repeated instances remedied by a cure of the malposition.

Such are the general symptoms of this disease ; but they cannot be considered as distinctive, although they are most important in pointing our attention to some derangement in the condition of the pelvic organs, and so leading us to more searching inquiries into the true cause of our patient's sufferings.

The *physical signs* afforded by vaginal examination

will alone yield us a correct diagnosis between retroflexion of the uterus, and those other local ailments, which equally give rise to many of the above symptoms.

On vaginal examination, what do we find? The uterus is usually somewhat prolapsed; behind the neck of the uterus, the finger discovers through the vaginal reflexion, and bulging between the rectum and vagina, in the situation of the recto-vaginal pouch of the peritoneum, a solid enlargement, an uniform roundish swelling, painful, sometimes acutely so, on pressure. Tracing the surface of this swelling forwards, we find it distinctly continuous with the neck of the uterus, at an angle more or less obtuse, viz., the angle of flexion formed between the body and neck of the uterus. The axis of the cervix will be found very slightly if at all affected. Here, then, we see a decided difference between it and simple retroversion, in which there is no such flexion, since in the same proportion as the fundus of the uterus is depressed posteriorly, the neck is in a corresponding degree elevated anteriorly behind the pubes.

In most of the cases we have found, that in consequence of interruption of the circulation at the seat of flexion, the cervix has become swollen from congestion, sometimes indurated, and in not a few patients excoriated, or even ulcerated. These conditions, however, we have easily remedied by treatment.

The diagnosis is made out by the above examination carefully conducted, conjoining therewith the use of the uterine sound.

I have already observed how we need not confound retroflexion with retroversion; but there are other diseases from which we have to distinguish it.

Thus, a fibrous tumour attached to the back of the uterus, and occupying the recto-vaginal pouch of the peritoneum already referred to, might for a time be mistaken for retroflexion; so also might an enlarged ovary lying in the same situation, a pelvic abscess, an uterine hæmatocele, a fæcal accumulation. So, on the other hand, might retroflexion of the uterus be confounded with any of the above conditions.

That the case is one of retroflexion of the uterus, although it may sometimes be complicated with one of the above diseases, can be decisively demonstrated, as may the converse, by the use of the uterine sound. Thus, if the uterus is in correct position, the sound, when passed up to the os uteri and onwards through it, will enter the cavity of the organ to the normal depth of two and a half inches, with the concavity of its curve looking forwards. In this case, we rightly conclude that the swelling perceived in the situation above indicated is not due to retroflexion, but to one of the above pathological conditions.

If, on the other hand, the case *is* one of retroflexion, the sound will not enter the cavity of the uterus in the natural direction beyond one inch at the most, it will then be stopped at the angle of flexion; but if we now, without removing the sound, reverse its position, so that its knobbed extremity points backwards and downwards, it will pass in freely to the

normal depth of the uterine cavity—viz., two and a half inches, and may easily be felt per vaginam by the examining finger through the wall of the swelling, which is thus proved to be the fundus and body of the uterus.

If now, without removing the sound, we turn it gently round in the uterus, and direct its point forwards and upwards, our left index finger in the mean time being applied against the displaced fundus of the organ, the bulging previously felt behind the neck of the uterus is felt to disappear—in fact, the uterus has, by this manœuvre, been reduced to its normal position.

Let us next withdraw the sound, we shall then find that the uterus relapses to its previous malposition; sometimes, as in chronic cases, quickly; in other cases, of shorter duration, more slowly. The diagnosis may now be considered as quite complete, the patient is undoubtedly suffering from retroflexion. (The use of the sound in thus clearing up the diagnosis was shown by a sketch.)

There is yet another advantage we obtain from the use of the sound; it enables us to ascertain the perfect mobility of the uterus, its lightness, and therefore its freedom from any outgrowth, when such is absent, and its independence of any contiguous tumour unadherent to the uterus.

In the employment of the sound it behoves us, however, to be very careful how we handle it, lest we inflict injury, and we must be mindful to omit its use

altogether, if we have the slightest suspicion that the patient is pregnant. You will have seen that, in two or three cases, I have on that account abstained from the use of the sound.

In a few examples of retroflexion, the sound cannot be introduced, owing to the extreme constriction at the angle of flexion. Here we may, however, in most cases, succeed in making out the nature of the case by very careful vaginal, rectal, and abdominal examination combined.

Yet another difficulty may occur to us, namely, should the uterus have contracted adhesions in its abnormal position, the use of the sound, whether assisted or not, will fail to reduce the organ.

Lastly, should any tumour, uterine or ovarian, or pelvic abscess, or an hæmatocele, complicate or have occasioned the displacement, these will be for us additional objects of inquiry and treatment.

In the *treatment* of retroflexion the first indication will be to reduce any congestion, inflammation, or hypertrophy of the uterus, to heal any abrasion or ulceration of the cervix, not unfrequent results of the displacement, and to remove any ovarian irritation.

At first absolute rest in the recumbent, and as much as possible in the prone position, will be necessary, and generally most agreeable to the patient. Should congestion or inflammation of the uterus be present, the application of four or five leeches to the neck of the uterus, applied through the tubular speculum, will be found most beneficial.

An ample discharge of blood is thus obtained, which should afterwards be encouraged by hot stupes to the vulva, or better still, by a hot hip-bath, followed by a return to bed. This depletive treatment may have to be repeated on a return of much local suffering, not relieved by warm applications and anodynes.

Any induration or hypertrophy remaining after the above measures have been resorted to may generally be removed by the bromide of potassium, also by the free application of the solid nitrate of silver over the cervix about twice a week, sometimes by the tincture of iodine similarly applied. The lunar caustic may also be applied in the same frequency for the treatment of granular ulceration of the cervix, sometimes complicating and frequently produced by this displacement; in other cases, an injection twice daily of subacetate of lead lotion is to be preferred (one drachm of Goulard's extract to one pint of water). Counter-irritation to the ovarian, sacral, and lumbar regions, or the local application of anodynes in poultices, enemata, or suppositories, will sometimes be indicated for the removal of neuralgic pains.

I have already intimated that perfect rest, in the recumbent, preferably in the prone posture, is most necessary, as well as most comfortable, to the patient, but sometimes the cares of a family have interfered with its due continuance. In the relaxed condition of the genital organs, and the feeble health which so generally attends this complaint, suitable tonics, with chalybeates, cold douche, cold hip bathing, cold water

vaginal injections, and a nourishing diet will be early indicated.

In those other cases of this malady requiring at first local depletion, a tonic regimen will also sometimes be usefully had recourse to at a later period. It is most necessary at the same time watchfully to regulate the bowels, a neglected state of them having not unfrequently had a considerable share in producing the patient's complaint.

In some cases the above measures will be all-sufficient in restoring the health of the invalid, the uterus recovering its natural position without further treatment. Of this fact you have had examples here.

When not so, we are then justified in resorting to the *mechanical treatment*.

Various have been the mechanical contrivances devised for the treatment of this malady. Thus, Dr. Simpson ingeniously designed a metallic stem, to be passed into, and left within, the cavity of the uterus. Two varieties of this instrument were constructed: in one it was connected with a frame-work applied in front of the pubes; in the other, the fixed point for the stem was placed within the vagina. I once saw the former in use in a patient in St. Bartholomew's Hospital, under the late Dr. Rigby; but it occasioned so great suffering, that he was compelled to relinquish its employment altogether. Such has been the experience of others also with fixed uterine stems; nay, in some instances, metritis, peritonitis, and even death have unfortunately resulted from their adoption.

Professor Kiwisch and M. Valleix contrived modifications of the same instrument, but equally objectionable in their principle.

I have myself, in a few instances, employed an intra-uterine metallic tubular stem, two inches long, having the same curve as a female catheter, perforated and mounted upon a small oblong plate. It has no fixed point of connection, is removed at the commencement of each period, and replaced at its conclusion. It is passed into the uterine cavity on the sound with its point directed backwards and downwards in the course of the flexion, and when introduced its entire length up to the plate, the sound, and with it the stem, is turned round. I believe it was designed by Dr. Tanner. Thus the organ is restored to its right position, which it has generally maintained, without fixing the stem in any way; but where it has not done so I have relinquished its use.

In many cases the presence of the stem, even thus unfixed, could not be endured; it was, therefore, at once removed. In one case under my care, and for which I was indebted to Dr. Cholmondley, perfect success was the result of its adoption, the instrument being worn for six months, except at "the periods," and with entire comfort. At the end of that time, the patient, who had previously been a great sufferer from her malady, was able to dispense with the instrument, being, as I ascertained, perfectly cured.

In another patient as yet under treatment, the tubular stem has been worn with perfect ease. The contrivance,

however, which, upon the whole, I prefer, is the gutta-percha loop pessary of Dr. Priestley, as I have modified it. It slightly resembles the letter S, and should vary in length and width with the vagina of different patients. The broad rounded extremity of the loop is adjusted behind the cervix, its lower constricted end is fixed to caoutchouc, or silk elastic tapes, which are attached behind and in front to an abdominal belt. To present a broader surface of support, a caoutchouc pocket has been sometimes applied over the uterine extremity of the loop. This india-rubber fixing, however, I find increases the leucorrhœal discharge, and renders it especially offensive; hence I have after trial discontinued its employment.

To supply the place of this pocket, where patients complain of the sharpness of the loop, I have had made for all cases, a thicker border, which thus affords a broader support, and saves the patient from that inconvenience.

Some patients reasonably enough complain of the external appendages to this pessary; others can wear it without them. The loop pessary of Dr. Hodge, of Philadelphia, is formed with the view of obviating external attachments; but having given it a trial in several cases, I have hitherto found it to slip from its proper place. Yet, in some cases, it may happen that the lateral pressure from the walls of the vagina may suffice to maintain this pessary in its right position.

To avoid external strings, I have used successfully

an elastic ring pessary, supporting upon its upper surface posteriorly a small elastic ball, for adjustment behind the cervix; and I have also employed a simple ball of caoutchouc with decided relief.

I have also employed a plug of cotton wool, pressed up behind the cervix, with decided improvement in one case now under my care, where the patient was too tender to bear any other contrivance, and I have found that it does not so soon become offensive as sponge or india-rubber appliances.

For cases in which any external projection at the vulva is intolerable, I have adopted a combination of the loop with an air-ring pessary.

Anteflexion of the Uterus.

Here the position of the uterus and the flexion is the converse of what it is in retroflexion. The *symptoms* are generally less urgent than those of retroflexion, difficult defæcation and dysuria less frequent, but partial incontinence of urine not uncommon. A sense of weight is felt in front of the pelvis. Leucorrhœa may occur, and the various menstrual derangements in different cases. Hysterical symptoms will be induced in some cases.

Vaginal examination discovers in front of the cervix the bulging formed by the displaced fundus and body of the uterus, as also the angle of flexion formed between the neck and body of the organ.

The sound passed into the uterine cavity, indicates the flexion to be forward; it enters the uterine cavity,

in fact, with its point directed forwards and downwards. This will be our guide in distinguishing this displacement from other conditions, which might be confounded with it, as, for instance, a tumour or other fulness occupying the same position.

We should be careful, however, when a suspicion of pregnancy exists, to omit, for an obvious reason, the use of the sound. In those cases where the sound cannot be passed, although the means of diagnosis are not so ready, there will seldom be much difficulty in eventually making out the displacement, by the taxis applied over the abdomen, behind the pubes, and examining the uterus per vaginam at the same time.

Treatment.—The patient should be placed on the back in this form of flexion. Any condition of the uterus, which may have led to the displacement, as congestion, inflammation, chronic enlargement, &c., should receive our first attention; and the removal of these will frequently be followed, without further interference, by a return of the uterus to its right position.

A relaxed condition of the genital tissues should be treated by cold water, or astringent injections into the vagina.

Neuralgic pains are to be met by anodyne applications, as in the like circumstances in retroflexion; the bowels duly regulated, and general debility removed by suitable tonics and diet.

Should these fail in removing the displacement, some relief may sometimes be derived from mechanical appliances. Too frequently, however, they are much less

easily borne in anteflexion than in the opposite displacement of retroflexion. If resorted to, they must be adapted to the local circumstances which distinguish the former from the latter.

I have, in these remarks on flexion of the uterus, confined myself to that malposition properly so called, as distinguished from anteversion and retroversion, which would deserve a separate consideration.

The following abstract of the cases which you have seen in my ward will suffice to illustrate the account which I have given you of the above displacement :—

1.—S. D., aged 37, widow ; phthisical ; has never been pregnant ; married only two years.

Cause.—Unknown.

Symptoms.—Dysmenorrhœa, also menorrhagia. Uterus enlarged, as well as retroflected. Neuralgic pain over right ovary ; worse in sitting posture. Painful defæcation and dysuria.

Treatment.—Os uteri opened by sponge tents, to satisfy a suspicion of an intra-uterine growth. None present. Regular attention to the bowels and rest. Discharged, much relieved. Mechanical treatment not admissible.

2.—A. L., aged 49, married ; phthisical ; has had four children.

Cause.—Feeble health.

Symptoms.—Profuse menstruation. Signs of retroflexion ; os uteri indurated. Right ovary slightly enlarged, probably by congestion. Dysuria. Partial numbness and loss of power, almost amounting to paralysis of lower limbs, most of right. Transferred to my care by Mr. De Morgan.

Treatment.—The loop pessary borne well and with good result. Recovered the power of walking. Reduction maintained. Laxatives as often as indicated. Rest. Tonics. Left free from lameness and in comfort, with the loop in application. Duration believed to have been four years.

3.—E. S., aged 36 ; married ; eight children ; been twice treated for ulceration of neck of uterus.

Symptoms.—Infra-mammary pain. Menorrhagia. Sound introduced passes downwards and backwards, the uterus being retroflected.

Treatment.—Os dilated by tent. Loop pessary applied. Bromide of potassium ; quinine.

Result.—Left the hospital much relieved, the loop in application, which gave her great comfort.

4.—S. S., aged 49 ; married ; twelve children.

Cause.—Has suffered ever since birth of last child, five years ago ; labour difficult ; confined to bed five weeks afterwards.

Symptoms.—Sense of weight in pelvic region ; leucorrhœa ; dragging pain in loins increased at each menstruation. Signs of retroflexion. Difficult defæcation and dysuria. Ulceration of os uteri.

Treatment.—The silver tube above mentioned was adjusted, and kept the womb in right position, but could not be retained on account of the pain produced. The loop was subsequently applied, but could not be borne any better.

Result.—The patient went out much relieved by rest and general treatment ; the ulceration cured.

5.—F. B., aged 23 ; married ; no family. Has suffered for two years.

Symptoms.—Right ovary felt enlarged and tender ; pain in loins and uterine region ; bearing down ; leucorrhœa ; cervix congested and tender, and the seat of granular ulceration. Severe pain in hip, leg, and foot of right side ; some of left. Signs of retroflexion to taxis and sound.

Treatment.—Leeches to os uteri with marked benefit ; nitrate of silver to cervix ; opium to relieve pain ; laxatives ; no mechanical treatment.

Result.—Left hospital relieved ; ulceration cured.

6.—E. R., aged 30 ; married ; four children.

Cause assigned, a miscarriage ten months ago.

Symptoms.—Menorrhagia ; leucorrhœa ; sacral hypogastric and lumbar pains ; no dysuria now ; difficult defæcation ; bowels

costive. Signs of retroflexion presented to taxis and sound; induration of cervix.

Treatment.—Goulard's injection; nitrate of silver to cervix; subsequently tincture of iodine; laxatives; no mechanical treatment.

Result.—Left the hospital without pain; the uterus having recovered its normal position and consistence.

7.—A. C., aged 42; married; eight children; has had four successive miscarriages, referred to syphilis communicated by husband.

Cause.—Lifting a heavy weight six months ago, hæmorrhage following from the uterus at the time.

Symptoms.—Leucorrhœa; menorrhagia; left ovarian pain; also in loins and inner side of thighs. Dysuria; sometimes incontinence of urine; micturition most easy in standing position. Difficult defæcation. Aching pain from tip of coccyx up the rectum; pain at navel. Abdomen pendulous. Signs of retroflexion.

Treatment.—Leeches to cervix; laxatives, with enemata; Goulard's injection; the loop pessary applied with elastic straps and abdominal supporter; tonics.

Result.—Discharged greatly relieved, and uterus kept *in situ* by the pessary.

8.—E. A., aged 37; widow; with six children.

Cause assigned, a protracted labour sixteen years ago, with descent of uterus, which afterwards increased to procidentia for the last seven years.

Symptoms.—Menorrhagia, with painful menstruation; leucorrhœa. Procidentia and retroflexion. Pain in loins, groin, and hypogastrium; dysuria; painful defæcation; left ovarialgia; great tenderness of displaced fundus; neck of uterus large.

Treatment.—Enemata and laxatives, with fomentations; uterus reduced, Zwanke's pessary adjusted as a temporary measure, which gave so much relief that the patient preferred leaving the hospital with it in application to trying the loop, as suggested.

9.—M. S., aged 23; married; two children; one miscarriage.

Cause assigned. Ten months ago had a fit of passion, when she

felt something give way in the pelvis, followed by excruciating pain.

Symptoms.—Painful and profuse menstruation; pain over left ovary, in loins also; leucorrhœa; dysuria; difficult defæcation; constipation.

Treatment.—Laxatives; loop pessary introduced, and gave comfort; the silver tube first tried, but had to be removed. Discharged convalescent.

10.—M. H., aged 30; married; one child.

Cause.—Difficult labour; ruptured perinæum; languid convalescence.

Symptoms.—When sitting up in bed, she feels "as if something pressed against the bowels;" dysuria constant and distressing; most comfortable in prone position; bowels costive; defæcation difficult; coitus painful; hypertrophy of cervix; pain over left ovary; dysmenorrhœa; leucorrhœa; signs of retroflexion. Duration of above symptoms eight years.

Treatment.—Bromide of potassium to resolve the induration; injection of lead lotion; tincture of iodine to cervix; loop pessary to be applied.

The above are the cases of this disease which have been treated in Prudhoe Ward during the twelve months ending July, 1864. It will be seen that they were all married women; two had never been pregnant; eight had families; in one twelve children; in two eight children; in one six children; in two four children; one had one child.

The respective ages of the patients were 37, 49, 36, 49, 23, 30, 42, 37, 23, 30.

We have seen that menstrual derangements were very frequently present. There are two cases of retroflexion, one with much relaxation of the tissues of the

uterus and its connections, the other with considerable induration from chronic metritis, now in the ward. The former is awaiting a loop pessary to be made to my order, those generally in use being found by this patient too sharp at the point of support. The latter case is to be treated by a few leeches applied to the cervix, followed by the exhibition of bromide of potassium, which I generally prefer to the bichloride of mercury. I might have added several cases from the out-patients, as also from my other sources of practice, bearing out the observation that the displacement is rare except in married women, and in those with families. I have at the present time under my care instances of the retroflexion of the uterus in two single ladies, aged twenty-seven, one awaiting her marriage, as soon as my permission is given. In both the sound is admitted easily into the uterus, and reduces the displacement by the movement already described.

It will be seen in the statistics subjoined of the cases of every form of disease under my care in Prudhoe Ward, that anteversion occurred but once.

ABSTRACT

OF ALL THE CASES ADMITTED INTO PRUDHOE WARD DURING THE YEAR ENDING WITH JULY, 1864.

Prolapse of the uterus, two of which amounted to procidentia	3
Retroflexion of the uterus	10
Retroversion of the uterus, complicating and produced by *fibrous tumour of uterus* in two, *ovarian dropsy* in one—viz., three cases.	
Anteflexion of the uterus	1
Dysmenorrhœa not connected with displacement of the uterus	5
Metrorrhagia without displacement of uterus ...	7
Menorrhagia, ditto	3
Ulceration of os uteri, or simple excoriation, not accompanying malposition of the uterus ...	9
Blood-poisoning after recent delivery, admitted with subsultus tendinum and mild delirium. Fatal	1
Phlebitis, phlegmasia dolens	1
Pelvic cellulitis after delivery, or suppressed catamenia	13
Carried forward ..	53

Brought forward ...	53
Simple uterine polypus	4
Fibrous or fibroid tumour of uterus; one with polypus, one fibro-cystic	6
Ulceration of bladder and urethra, chronic, with great emaciation, preceded and accompanied by fissure of the rectum, operated on before coming to this hospital, and subsequently relapsing	1
Ovarian dropsy	13
Pregnancy detected by auscultation, but sent in as ovarian tumour	2
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SUMMARY OF CASES.

Of the cases of *prolapsus of the uterus*, all admitted of treatment by pessaries, the perinæum being intact.

One by ring-pessary, found to suit the patient best; but some days elapsed with the procidented uterus much swollen and ulcerated, and I had to support it elevated on a pillow before it could be reduced. *Two* by Zwanke's pessary. The patients, who had been long disabled, were then competent to follow their occupations. They had all had several children.

Of the cases of *polypus uteri* attended by the usual flooding, four in number, in each the growth was abscised, and the patient left in due time convalescent.

The cases of *ulceration of the os uteri* unaccompanied by displacement were treated locally by Goulard's injection, a few by the application of the solid nitrate of silver, and went out cured.

Of the cases of *fibrous or fibroid tumour of the uterus*, marked relief to pain was obtained by leeching the os uteri, and by pushing the bromide of potassium.

In *two*, decided reduction in the size of the tumour was thus obtained; one of these, whose sufferings had been excruciating, so as to excite a suspicion of carcinoma of the body of the uterus, and who was trans-

ferred to me by Dr. Stewart shortly after admission, is now in comparative comfort, and continues the bromide still.

Another case of fibroid tumour, also, on account of the agony of her pains, suspected to be carcinoma of the body of the uterus, scarcely relieved by opiates, appeared to me, as proved to be the case, one of painful distension of the uterus by an included tumour. The neck was incised, having previously been somewhat prepared by a tent; the tension of the uterine walls was thus removed, and the patient so thoroughly relieved from her suffering, that she was able to leave the hospital in comfort three weeks after.

Incision was adopted with great relief in another, to pain and flooding; but tetanus followed on the third day, fatal on the fourth. It proved to be a fibro-cystic tumour of the uterus.

Of the cases of *ovarian dropsy*, thirteen in number, which came under my care, tapping was performed in one, a single cyst, by Mr. De Morgan. The patient was watched for several months after, and the dropsy did not return. She was able to return to service in good health.

The following are the particulars of the ovarian tumour in the remaining twelve cases:—

1.—Sophia White, admitted July, 1863, a widow, aged 47. Stout, with brown hair; a cook. Menstruation began at 11 years; always been regular. Has had three children. Cyst extends from right iliac region, which is painful, to above umbilicus. No enlargement

or displacement of uterus. Erysipelas in right leg after admission, speedily removed by collodion, recommended by Mr. Nunn. Went out improved in general health. Not suited for ovariotomy.

2.—Martha Mee, August 25, 1863 ; bed 4 ; widow, aged 41. A small thin woman. Menstruation delayed to 21, and had ceased eleven years. No children. Ascitic fluid distinctly perceived between ovarian tumour and abdominal wall. Tumour more prominent on right side, irregular on surface, and moveable. Circumference at umbilicus, 34 inches. Commencement dated to ten years back. No albumen in urine ; lithates abound ; sp. gr. 1,020 ; 26 ounces in twenty-four hours. Subsequently by diuretics increased to 40 ounces.

Treatment.—Iodide potassium. Syrup of iodide of iron was later substituted, and cod-liver oil was also given. Left hospital much improved, having latterly taken perchloride of iron with quassia. Had also ulceration of rectum just above sphincter ; treated by nitrate of silver by Mr. Moore, and successfully.

3.—M. A. Sullinger, admitted October 6, 1863 ; bed 2 ; aged 48 ; widow ; eleven years. Muscular development good. Five children. Tumour first noticed four months ago. Girth at navel 35 inches. Tumour apparently affects right ovary, and extends to $2\frac{1}{2}$ inches above the navel ; fluctuation distinct on right and left side of tumour. No albumen in urine ; sp. gr. 1,018. Tapped by Mr. De Morgan, nine pints of milky-looking serum drawn off.

Discharged, relieved, on the twenty-fourth day, November 11, 1863. Subsequently re-admitted, February 5, 1864. Ovariotomy, no adhesions, February 24. Fatal by peritonitis, March 2.

4.—Hepsibah Estell, October 20, 1863 ; bed 7 ; aged 32 ; married ; three children. Medium stature. Slight muscular development.

A year and a half ago had pain in left groin. About a year ago, tumour was first noticed. For last six weeks she has had drainage of a watery fluid from a small opening near the navel. Superficial veins over abdomen, and emaciated chest walls observed to be enlarged ; fluctuation distinct through abdominal parietes, over right half of abdomen, not over left. A largish nodule felt in right

ovarian region. Right leg anasarcous; two abrasions of skin on middle third of right leg anteriorly and posteriorly.

She was tapped by Mr. Nunn, October 21; 30½ pints removed of olive-brown viscid fluid. Greatly relieved, a good night's rest following. Died October 26, of peritonitis.

5.—Keziah Bee, aged 45; married twenty-seven years. Thin. One child. She first noticed a swelling on left side ten years ago. Had a fall a fortnight ago, since which the swelling has increased. Apparently a single cyst of right ovary, with thin walls. She lies most easily on left side; lips pale. Pulse 76, feeble; tenderness of epigastrium. Girth at umbilicus, 35½ inches; subsequently 37 inches. Œdema of face when lying, of ankles when standing. Cough troublesome.

Treatment.—Linctus for cough; laxatives; perchloride of iron.

Discharged much relieved and improved in health. Not favourable for ovariotomy.

6.—Susan Talbot, aged 44; married; thin; careworn; seven children. Commenced menstruation at 15; has been very irregular in her periods. Attention was first drawn to her case seven years ago by pain in right pelvic region. About five years since she began to swell all over the abdomen rather suddenly, and it has continued with very little increase to the present date.

Present state.—Abdomen greatly distended. Girth 43⅜ inches. Dulness everywhere except at lower part of abdomen on right side. Per vaginam enlargement felt anteriorly at vaginal reflexion. Operation proposed with usual cautions, but not assented to by patient.

Discharged about the same as when admitted.

7.—Harriet Sutton, in Bird Ward temporarily, aged 29; married fourteen years; admitted February 9, 1864; four children. Menstruated at 12; regular, except when pregnant and suckling, till last May. First noticed after birth of her child, two and a half years ago, a swelling in right iliac region size of a fist; it afterwards grew rapidly towards middle line, and in three months after her confinement the patient was larger than when pregnant. She

was then tapped by Mr. Hancock, of Charing Cross Hospital; 13 pints of fluid drawn off. About a month later the swelling reappeared in right iliac region; in six months it was as large as ever. She was then tapped a second time to 13 pints. Nine months afterwards a third time, 17 pints removed. And now she is as large as before. Has lost flesh last six months. No dyspnœa. Heart's sounds normal. Fluctuation very distinct everywhere except in right iliac region. Superficial veins of abdomen greatly enlarged, as also on emaciated chest walls. Uterus normal. A hard rounded nodule found above vaginal reflexion on left side. Urine, no albumen; sp. gr. 1,016. Operated on by ovariotomy; some adhesions. Fatal by peritonitis on the fourth day. The left ovary had been removed; right normal. For the operation and after-treatment she was placed in a ward by herself for quietude and good air, a plan which has been adopted here in all ovariotomy cases.

8.—Rebecca Herald, aged 31; married; no children. Came in with inflammation of ovarian cyst, attended by distressing vomiting. Admitted March, 1864. She menstruated regularly till six months ago.

Last October had a copious discharge from the vagina of dark fluid for five days, attended with intense pain in left pelvic region; but she thinks abdomen was enlarged before that. The tightness disappeared on the discharge; but soon abdomen enlarged again, and pain in left ovarian region confined patient to bed. Twice since has had a discharge as before of a dark fluid. The enlargement after this again increased; and six weeks before her admission patient was seized again with pain in same situation, which continued till her admission.

Present state.—Abdomen now greatly enlarged; exquisitely tender over left iliac region. Countenance anxious. Per vaginam, through its reflexion on left side, a soft swelling is felt, very tender to the touch, not moveable. Neck of uterus deviates to left side. Tongue thickly coated with a white fur. Pulse 74. Bowels regular. Urine normal.

Six leeches to left ovarian region.

The constitutional disturbance was entirely removed by the treatment. No pyrexia, tongue clean, appetite good, and sleep,

and she left for her home, Cambridge, unwilling to undergo ovariotomy, which was mentioned to her with the usual cautions.

9.—Ellen Moran, aged 29, single, lives at Bromley. Admitted March 22, 1864. Bed 3. Menstruated at 11; regular ever since. First noticed enlargement of abdomen eight years ago in right iliac region. On right of linea alba are several masses; larger half of tumour to right of middle line. Emaciated, pallid. Arcus senilis. Looks old for her age. Conjunctiva dirty yellow. Girth at umbilicus, 40 inches. No enlargement to be felt per vaginam. Uterus elevated; no vaginal projecting portion. Tongue clean. Pulse 90. Urine 1,010; no albumen.

Treatment.—Mercurial alteratives; laxatives; perchloride of iron.

April 8.—General health improving.

May 9.—Discharged, better in health, but not considered a good subject for operation.

Feb. 21, 1865.—Came in again by her own desire. I find her decreased in size, and her health as when she left. Girth at navel 28 inches. Fluctuation on each side of tumour; but not from side to side. Uterine sound enters uterus $4\frac{1}{2}$ inches, and in right direction. Breathing only difficult when she goes up stairs. Breath and heart sounds normal. Veins of left leg varicose; appetite good; urine, no albumen; sp. gr. normal. I discharged her for the country on Feb. 28, not advising ovariotomy.

10.—Mary Jacob, aged 50, admitted into Prudhoe Ward, April 2, 1864; bed 5; widow; seven children. Catamenial and labour histories good. Menstruated a month before admission. Dates her first notice of enlargement from Christmas. It commenced on left ovarian region.

Present state.—It now occupies hypogastrium, extending nearly to umbilicus. Lies best on left side; feels a dragging when lying on right side. Girth at navel 38 inches, partly due to ascites, clearly perceived over the tumour, which is distinguished readily on displacing the dropsical fluid.

Anasarca of right leg and varicose condition of it. Subcutaneous veins of abdomen slightly enlarged. Respiration rapid; pulse 110. Decubitus on back oppresses the breathing.

Phthisis suspected, from dull percussion-note below left clavicle and over apex of left lung behind. Expiratory murmur prolonged, inspiratory murmur feeble. Normal respiration below right clavicle. Heart's sounds feeble, with a systolic murmur. Walls of chest emaciated, arms and face also. Urine, sp. gr. 1,012 ; 32 ounces in twenty-four hours ; slight trace of albumen. Vision clouded when she looks upwards. Later, large crepitation pervaded the lower half of left lung from œdema.

The ascites and anasarca were reduced by diuretics, combined with chiretta, so that she could lie down with comfort, and she left at the end of about two months greatly improved. I did not propose ovariotomy, as her health was against it. She was subsequently attended from a dispensary, and by her desire I once saw her, as it had been proposed to tap her, and she recollected that I had been opposed to her wish for that relief when she came into my ward. I still thought that with the help of medicines tapping might again be postponed. She lived some months afterwards, was then tapped, most probably unavoidably, and died in a few days after.

11.—Ann Hyde, aged 36 ; married ; two children. Admitted into Prudhoe Ward ; bed 8 ; May 17, 1864. Is tall and rather stout ; dark complexion. Menstruated at 14. She married at 19. Good health up to present illness. About Christmas was first taken ill with pain in the hypogastric region. She yet had to do for her family, which caused her great pain and debility. A brownish watery discharge appeared from the vagina. No dysuria nor difficult defæcation ; floodings. This continued till she came into the hospital.

State on admission.—Neck of uterus tilted upwards behind the pubes, so as not to be reached by an ordinary examination. A tumour occupies abdomen, extending from pelvis to navel ; more of it found on left of middle line. Body of uterus felt per vaginam to be expanded by some contained tumour. No pyrexia. Much pain at the menstrual periods. Bladder and rectum disturbed. Hæmorrhoids. Girth at umbilicus 44 inches. Menses now present. Urine not albuminous, sp. gr. 1,010, phosphatic. Tumour had been diagnosticated as a fibrous tumour of uterus by an obstetric physician at another hospital eastward. I was dis-

posed to the same view, from its central position and want of fluctuation.

May 31.—Such was her severe suffering that I determined on pursuing the same course I had adopted successfully in the case of fibrous tumour, bed 6,—that of incising the cervix, so as to take off the tension of the walls of the uterus over the growth. I performed it to-day, after first opening the os uteri with tents, and to my surprise a cyst was laid open, which, as proved subsequently to be the case, had bulged into the uterine cavity from the left ovary. It discharged about a quart of fluid, and continued to discharge throughout the night and part of the following day. She was greatly relieved by this operation, and went on comfortably till June 5th, when after a bad night, apparently caused by the shock of a death in the ward and other effects, she was taken worse, and died on the 7th. Up to that she was herself very sanguine, and I had great hopes at least of a temporary recovery.

Necropsy.—Twenty-nine hours' *post mortem* ; a large quantity of lymph smeared over the peritoneum in the pelvis. Vivid injection, and numerous small ecchymoses. The uterus somewhat enlarged. United closely to its left side and posterior wall was a cyst, containing half a pint of dirty serous fluid and some pus. Its lining membrane was moderately smooth and its walls fleshy, about four lines in thickness. It consisted of left ovary altered by disease, for the left ovary in a healthy state was nowhere to be found ; the right was normal.

The left Fallopian tube ran along the upper surface of the growth, and then turned down over its posterior surface, and its extremity was attached to it. The cavity of the uterus was somewhat dilated, and its posterior wall bulged forwards by the tumour. The cavity of the tumour communicated with the cavity of the cervix uteri by a longitudinal opening one inch in length made by the incision above described.

The right ovary contained a cyst the size of a bean.

The only other morbid appearance was in the abdomen ; here the peritoneum contained a large quantity of brownish turbid fluid ; the serous surfaces covering the intestines smeared with soft yellowish lymph. This account is taken from the official book of the hospital, kept by our pathologist, Dr. Cayley.

Ovarian Tumour.

12.—Mary Randall, aged 48. Admitted July 15, 1864, into Prudhoe Ward; bed 8. A widow; her husband died on the third day of her marriage. She had been a military sempstress. She menstruated at 15. When 18, the menses were suddenly suppressed by cold; but no illness then followed, and she again became regular, and continued to be so, and in good health otherwise, till ten years ago. She then discovered a solid tumour in her abdomen, painful on pressure, about the navel. The tumour steadily increased in size, and she complained of dragging pains at the umbilicus.

At the menstrual periods it diminished, and was less solid to the taxis, and again enlarged in the intervals. She has had pain of a dull continuous character generally over the whole abdomen and in loins, with occasional attacks of vomiting. Is of a costive habit. Frequent dysuria. She entered St. Bartholomew's; but being soon discharged as incurable, she came to the Samaritan, and was admitted. She stated that she had been rendered miserable by pain and dropsical swelling of the legs. Mr. Spencer Wells recommended ovariotomy; but the patient declined. Eight months later she applied to Mr. Wells for readmission, and then was willing to submit to operation; but her condition from sickness, emaciation, pain, sleeplessness, was now much worse. She had also much dyspnœa; pulse 104; mitral bruit; much dysuria. Girth 57 inches; distance from xyphoid cartilage 27 inches; from right anterior superior spine of ilium to the umbilicus 20½ inches; same measurement on left side 22 inches. The uterus per vaginam could not be reached.

June 25.—Mr. Wells tapped her at a fluctuating point, and drew off five pints of bloody-looking fluid.

June 29.—The suture pins were removed, and four more pints drawn off. Another cyst above and to the left of the last was then opened, and 23 pints of bloody fluid escaped. About a quarter or a fifth of this was pure blood. That night the patient slept for the first time for more than a month, and next morning was much better.

July 1.—The pins were removed from the integuments, and the patient left the hospital, Mr. Wells deeming the case no longer a suitable one for ovariotomy.

Mary Randall, at the above date, July 15, was then admitted under my care at the Middlesex Hospital.

Her girth around navel was now 57 inches.

I found her emaciated, very sallow, eyes sunken, features sharp, deeply furrowed. She had nausea and vomiting, bilious diarrhœa; urine scanty, turbid. Abdominal walls tense, œdematous; cutaneous veins moderately large; dull pain over whole of abdomen; ribs very prominent; mammary veins turgid. Pulse 104, small, wiry; respiration 28.

Treatment.—Diuretics, and sedatives of sickness, as effervescing salines, hydrocyanic acid, ice to suck, were given, and subcutaneous injections of morphia resorted to for pain and restless nights, with much relief. At the same time I directed a laxative enemata to be administered as required. Stimulants, as sherry, brandy, were also given as needed. I judged it unsafe to tap her until rallied somewhat.

July 21.—Girth of abdomen 59½ inches. Urine 1,017; no albumen. Pulse 96; respiration 24.

July 23.—She being rallied, I requested Mr. De Morgan to perform paracentesis, and he removed seven pints of chocolate-coloured fluid, which being thick, came away slowly; two or three pints more drained off in the night.

July 24.—Febrile disturbance; pulse 100.

July 26.—Pulse 120, small; respiration 36, heaving. Tongue dry, chapped; thirst extreme; skin dry, hot.

July 27.—She gradually sunk, and died at 6·30 a.m.

Necropsy.—The lungs were œdematous, but crepitated. Heart-valves normal.

Abdomen filled with a lobulated tumour, which extended from the pelvis to the cartilages of the ribs. The intestines were situated above and behind it. The liver, although of large size, lay entirely beneath the ribs. The tumour was adherent to the anterior abdominal wall over a very large space; but the adhesions were slight, and easily torn through. The peritoneal cavity contained some turbid brown fluid mixed with blood; this was oozing freely from a puncture in the tumour corresponding to the trocar wound in the abdominal walls.

Posteriorly, the upper part of rectum and descending colon were

closely united to the tumour ; but with the exception of this, and the adhesions in front, the tumour was everywhere free, except a broad attachment to the uterus and ovaries. The uterus and vagina were drawn upwards, and much elongated, forming a tightly stretched tube ; both the ovaries were also drawn upwards, the right one being attached closely to the tumour. At first, the tumour appeared to have grown from the fundus and back of the uterus, towards right side ; but the uterus was found on dissection to be perfectly distinct from the tumour, which, on a more thorough examination at leisure, proved that it had evidently been a production from a superficial part of the right ovary ; for the far greater part of the right ovary was perfectly healthy. The left ovary had no connection whatever with the tumour. Dr. Webb, our histologist, and Dr. Ritchie, who had seen the case at the Samaritan and obliged me with his notes of her condition and treatment there, and felt naturally an interest in it, were associated with me in this inquiry ; and although at first it appeared to have no connection with the ovary, but rather with the uterus, or with the Fallopian tube, analogy led to more minute investigation, which established its connection with the right ovary.

The tumour itself was made up of solid masses, many as large as a fœtal head ; also of cysts, with thick fleshy walls. The largest cyst, in which was situated the trocar wound, would have held about two quarts. It was filled with a turbid brown fluid, very offensive, and also some large recent blood coagula. Its walls were traversed by thick projecting fibrous bands. This large cyst appeared to communicate with other ones in its neighbourhood, which were filled with the so-called colloid fluid. The solid masses, which were formed of a tough fibrous stroma, were also full of small cysts, containing brown colloid fluid. The fleshy walls of the larger cysts themselves contained numerous cystic interspaces, filled partly with brown serum and partly with a colloid fluid.

The weight of the tumour, allowing for the fluid which had escaped at the necropsy, was forty-five pounds. The above is from Dr. Cayley's Post-mortem Register, belonging to the Middlesex Hospital, excepting in regard to the subsequent inquiry as to the origin of the growth from the stroma and vesicles of a superficial part of the right ovary.

Of the *cases* of pelvic cellulitis, thirteen in number, *two* had had former attacks, most had a puerperal origin. The exceptional cases arose from suppressed catamenia from cold.

All the patients did well, although many of them exhibited considerable deposits of fibrine in the cellular tissue adjacent to the uterus, accompanied by much enlargement and fixity of that organ, with constitutional disorder.

Abscess followed in *nine* of the cases.

In *four* opening into the rectum.

In *three* into the vagina.

In *one* externally in the groin.

In *one* just below the navel, requiring an incision.

Four cases terminated in recovery without suppuration. Two cases were complicated by ascites.

In two of the cases following acute suppression of the menses, one transferred to me on admission by Dr. Greenough, the uterus was found enlarged to the size of a five months' gravidity, and pregnancy was suspected; but the history and the character of the enlargement, with the symptoms, decided against the suspicion, which the result confirmed.

The cases of more profuse *metrorrhagia or of menorrhagia* were treated by intra-uterine injections of a solution of the pernitrate of iron, or of the perchloride, and with marked success in all, and no evil results. Forty minims to a pint of water was the strength, one ounce being used at a time.

The cases of *dysmenorrhœa* were mostly relieved by

the following several means: local leeching, hot hip-baths, anodyne applications, dilatation of the os uteri, followed by constitutional remedies directed to the improvement of the general health.

The number of cases was limited by the area of the ward, which admits at one time only eight patients.

I am indebted for the reports in the Hospital Case Book from which I have made the above abstract to my former obstetric assistants, Mr. John Smith, and Mr. William Freeman, now Resident Medical Officer at the United Bath Hospital.

THE END.

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