A radical operation for procidentia : read before the New York Obstetrical Society, December 20, 1864 / by Thos. Addis Emmet.

Emmet (T. A.)

A RADICAL OPERATION

FOR

PROCIDENTIA,

READ BEFORE THE NEW YORK OBSTETRICAL SOCIETY,

DECEMBER 20, 1864,

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Mr. President,—

My predecessor, Dr. J. Marion Sims, after a number of operations in the Hospital for the relief of this condition, finally abandoned the different methods recommended for partial occlusion of the vagina.

Where the canal was narrowed by uniting the edges of an ellipse (formed by removing the mucous membrane from the base of the bladder), a failure generally resulted, except when the vagina was short, as in advanced life.

It was demonstrated, by bringing together in the axis of the vagina two parallel bands, extending from near the outlet to the neck of the uterus, that a great advance had been obtained.

But the relief was only a temporary one. The surface turned in, and gradually insinuated itself sufficiently between the neck of the bladder and the septum thus formed, to reproduce finally the original difficulty.

This was effected, either by crowding the septum backward, or by gradual absorption of the recently united surfaces.

This fact led Dr. Sims, in February, 1858, to commence the scarification near the neck of the bladder, with two denuded surfaces, from a common point, in the form of a triangle, diverging to each side of the cervix uteri. These surfaces were brought together with interrupted silver sutures in the median line. By so doing, the neck was crowded towards the cul de sac, and a fold of the vagina formed in front of the cervix, which effectually prevented any prolapse of the uterus.

Previous to the time of Dr. Sims' removal to Europe in 1862, we both had operated frequently without the necessity for any modification occurring.

In September, 1862, after three months of great suffering one of the first patients operated on by Dr. Sims in this manner, presented herself at the hospital, for relief. She stated that, during four years, she had been entirely relieved by the operation, when, suddenly, (while in the act of lifting) she was seized with a persistent tenesmus, greatly aggravated in the upright position.

On examination, the line of union was found perfect, with no prolapse of the vaginal wall. But the neck of the uterus had slipped behind the septum into the pouch, thus throwing the fundus into the hollow of the sacrum, and fixing the organ in this position. With great difficulty, the neck was disengaged. On returning the uterus to its normal position, immediate relief was obtained, and she was discharged without further treatment.

On reflection, it became evident that the occurrence of this accident would be in ratio to the extent of the previous procidentia. The more complete the procidentia from relaxation of the vaginal walls, the greater the pouch resulting from the amount of tissue folded in.

From mal-position, the whole organ (but more especially the cervix) is always greatly hypertrophied. After a restoration to its normal size, the neck being no longer grasped by the fold, the latter would naturally in time override the cervix, and force it into the pouch. Nor could this result be guarded against, although the line of union be extended at the time of operating, so as to crowd the cervix uteri fully into the cul de sac of the vagina.

Impressed with these views, I succeeded in obtaining an examination of two cases, operated on by me, some eighteen months before. In both, the neck was found entirely behind the septum, but producing no inconvenience, beyond a backache, following any undue exertion. Both had experienced entire relief for a long time, but feared that they were gradually relapsing into their old condition.

In September, 1862, Mrs. C., aged 30, the mother of four children, was admitted to the hospital, with complete Procidentia of ten years' standing. She had been frequently irregular, and, during the first examination, the attending physician having passed the sound, a miscarriage took place soon after at the third month of pregnancy. On the 10th of October following, I proceeded to operate, by removing the mucous membrane from the base of the bladder, in two broad bands, extending from the point B, a little behind the urethra, to A and C, on each side of the cervix, as recommended by Dr. Sims.

The scarified surfaces were then connected from A to C, just in front of the cervix uteri, for the purpose of closing the pouch; thus forming, when brought together, a firm, unyielding support, and rendering it impossible for the neck to slip behind the septum.

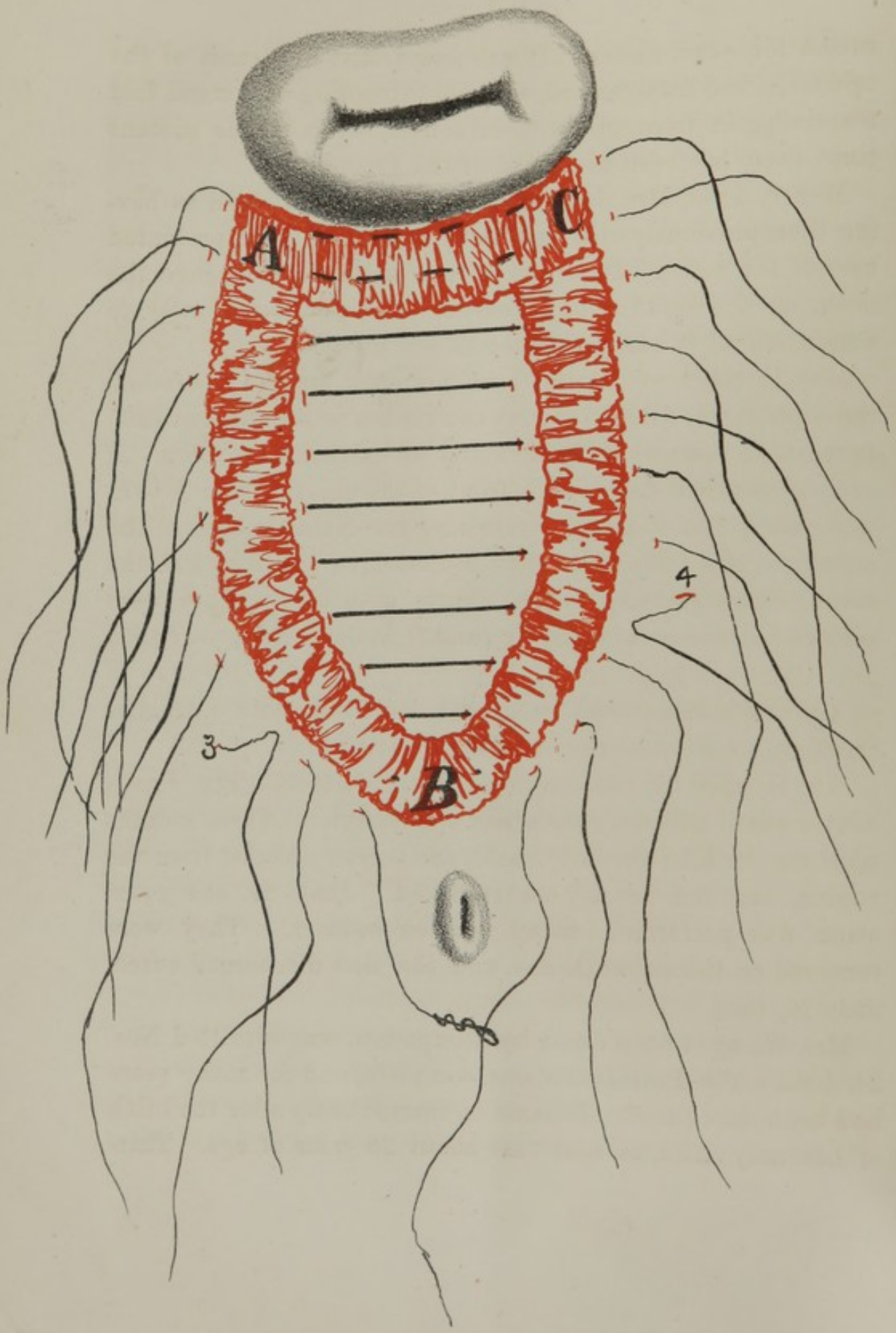
The two sutures nearest the cervix uteri, were passed as a running stitch, so as to include as nearly as possible the entire scarified surface of the transverse section. The others, from above downwards, were made to skip over the undenuded triangle, and only to embrace the opposite scarified surfaces. The last one, however, at the neck of the bladder, passed from side to side, including the whole tissue as at the cervix uteri. Thirteen interrupted silver sutures were used; they were removed on the thirteenth day, and the case discharged cured November 2.

Ten months afterwards, she was delivered of a very large child, and had a natural labor. Several months after her delivery, I made an examination, and found the organ in a healthy condition, with no trace of the operation remaining in the vagina. By passing a sound into the bladder, and the finger approximated by the vagina, it was demonstrated that the base of the bladder had regained its natural thickness.

On inquiry, I learn that, up to the present time, she is in perfect health, and has continued to follow her occupation as a washer-woman, with no recurrence of the Procidentia.

Mrs. P., aged 63, the mother of eleven children, was admitted December 31, 1862, with complete Procidentia of twenty years' standing. She was operated on the next day, as in the previous case, using eighteen sutures. She proved very unruly, refused to take any opium, and constantly made the most violent efforts in straining, with the idea that a movement of the bowels was imminent. The sutures were removed on the fourteenth day, a perfect union had taken place, and she was discharged cured, February 14, 1862.

Eighteen months after the operation, she visited the Insti-


A
C
B
3
4

tution for examination. It was found that all traces of the operation had disappeared, with the exception of a small fold remaining in front of the cervix uteri. Up to the present time, there has been no return of the Procidentia.

May 6, 1863, Mrs. H. (the case already mentioned as having been previously operated on by Dr. Sims), again presented herself for relief. It was now impossible to disengage the neck, as the septum had become stretched sufficiently to admit behind it a large portion of the uterus.

May 11, the case having been prepared for the operation, the septum was divided (about two inches in the median line) from above downwards, sufficiently to extricate the neck. A surface was then denuded in front of the cervix (from A to C, as shown in the diagram) connecting the divided edges of the septum. The uterus was then replaced in position, and the surfaces brought together by fourteen sutures. They were removed on the eighteenth day, and the case discharged cured, June 14.

A year afterwards she reported herself well, with a promise to return on any recurrence of the difficulty.

Mrs. C., aged 27, was admitted June 22, 1863. The Procidentia was of five years' standing, and complete. Three months after the birth of her only child, the uterus escaped from the vagina, and had never been returned. June 29, the operation was performed, using sixteen sutures. They were removed on the eleventh day, and the case discharged cured, July 20, 1863.

Mrs. W., aged 64, a nurse by occupation, was admitted Nov. 24, 1863. The Procidentia was complete, and for many years had been unreduced. It came on immediately after the birth of her only child, at that time about 25 years of age. Thir-

teen sutures were used; they were removed on the ninth day, and the case discharged cured, December 18.

This patient, in excellent health, reported herself for examination December 15, 1864. As in the other cases, no trace remained of the operation, with the exception of a slight ridge or fold in front of the cervix, and this even could only be detected by means of the finger.

Mrs. O., aged 27, the mother of two children, the eldest being six years of age, was admitted January 5, 1864. A few hours after delivery, she got up for the purpose of washing her clothing. She soon felt the descent of the uterus, but the Procidentia did not become complete for six months afterwards. In 1862, she again conceived, and states positively that the Procidentia remained unreduced from the first occurrence, until the latter months of pregnancy, and recurred immediately after delivery. On admission, the sound passed nearly four inches to the fundus, and the neck was immensely hypertrophied. January 16, I operated, using seventeen sutures. They were removed on the twelfth day, and the case discharged cured, Feb. 14, 1864, with the promise to report herself if any recurrence took place.

Mrs. S., aged 64, admitted Jan. 25, 1864. She was the mother of eight childen, the youngest being twenty years of age. On the eighth day after delivery, she got up, and shortly afterwards began to suffer from a partial prolapse, but it was several years before the uterus escaped entirely from the vagina. For five years previous to admission, it had been unreduced, and, during that time, the necessity always existed for a partial reduction, before the bladder could be evacuated. Jan. 25, the operation was performed, using fourteen sutures. During the night, she got up and walked about the ward for

several hours, and continued, in spite of all remonstrance, to follow her own inclination. On the twelfth day, it was discovered that four sutures (near the neck of the bladder) had torn out, and through the gap a portion of the relaxed base of the bladder protruded. The sutures were all removed at the time, and every hope of success abandoned. Before her discharge, it was found on examination that the entire line of union had gradually parted, with the exception of the cross scarification, in front of the cervix uteri. The fold thus formed (as in a sling) had retained the organ perfectly in place, although below, a Cystocele existed. The result was attributed to the fact of her being of a spare habit, with a vagina short, in consequence of her age. I have been informed within a few weeks, that there has been no return of the displacement, and, although partially in her dotage, she continues still to lead an active life.

Future experience must demonstrate how far the formation of this fold can alone be relied on under other circumstances; yet it is evident that in many cases this will prove all that is necessary to retain the uterus in situ. When atrophy of the organ has taken place and the vagina shortened consequent upon a change of life, it is believed, after this fold is formed, that no great amount of the vaginal wall can prolapse.

Mrs. D., aged 42, the mother of eight children, was admitted Feb. 8, 1864. On the third day after the birth of her first child (fourteen years previous to admission), she got up, and the uterus came down to the outlet of the vagina at once. Complete Procidentia gradually resulted, and continued unreduced, except during pregnancy. A change of life had already taken place some two years previous to admission. The operation was performed Feb. 10, using sixteen sutures;

they were removed on the tenth day. The four lower ones were found to have cut out. The surface, however, gradually healed by granulation, and the case was discharged cured, March 1, 1864.

Mrs. P., aged 39, the mother of two children, was admitted April 5, 1864. Four years previous to admission (while pregnant with her last child), the uterus remained very low down in the vagina. At the eighth month, it partially protruded, and remained in this position until a few hours before delivery. She confined herself to her bed for six weeks afterwards, but immediately on getting up, the Procidentia became complete. Operated June 12, using seventeen sutures. They were removed on the tenth day, and the case discharged cured, July 4.

Mrs. S., aged 41, the mother of two children (the youngest twelve years of age), was admitted May 12, 1864. The Procidentia had been complete for nine years, but she was able to reduce it herself, and was comfortable by retaining the uterus within the vagina by means of a bandage. The operation was performed May 24, using sixteen sutures, and the case discharged cured, June 20 following.

Since October, 1862, I have operated by this method in public and private practice on seventeen cases successfully, and with every reason to believe that there has not been a single recurrence of the difficulty. I have avoided giving the history of any but of those residing in the city or immediate neighborhood, where a frequent examination has been possible, and their exact condition known at the present time. In other cases, failure has resulted; but in every instance, it was in consequence, either of great tension, from including too much tissue at the time of operating, when the result was often anti-

cipated, or to a want of necessary care on the part of the patient afterwards.

Previous to the operation, if much excoriation exists, it is necessary to reduce the Procidentia, and keep the patient in bed for a few days. One or two applications of a weak solution of the nitrate of silver will usually heal any excoriated surface; and large vaginal injections of warm water, night and morning, will be sufficient in a short time to remove the dry and scaly condition of the long exposed surface. If more than this is necessary, after each injection a portion of damp cotton should be used, thoroughly saturated in glycerine, and carefully spread out so as to come in contact with the entire canal, the whole being kept in situ by a bandage. This will, by the watery discharge induced, greatly lessen the congested condition of the blood vessels, and so corrugate the vaginal walls, for the time being, as to afford quite a support to the uterus.

The patient having had the bowels thoroughly moved the night before, should be placed for the operation on the left side, in Sims' position for the operation of Vesico Vaginal Fistula, or uterine examination, and his speculum used.

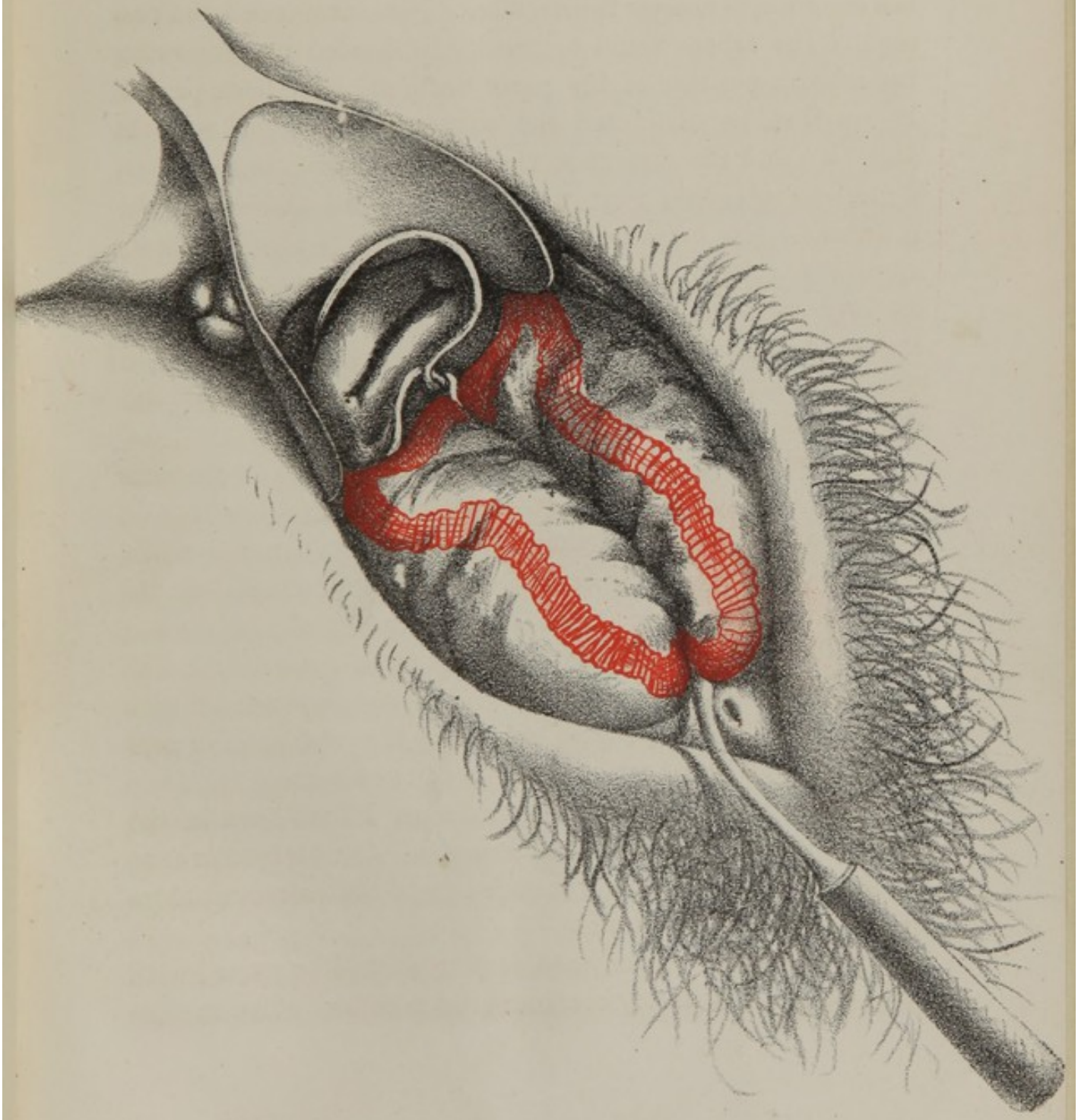
It is often exceedingly difficult to keep the proper line for scarification, in consequence of the mobility of the parts. The process, however, is greatly facilitated by an assistant, firmly depressing the prolapsed base with a sound, directly in the median line—a resort often made use of by Dr. Sims. But, even when the assistant is accustomed to the operation, the sound will frequently slip to either side of the cervix uteri. This being generally hidden from view, and having no other guide, the scarification will be found deflected. To obviate this, I often bend the end of a flexible, plated, copper sound,

in a circle, sufficiently large to slip over the neck as a collar, and again properly curved on itself, so as to keep up the base at the same time. I am now having an instrument made for the purpose of disconnecting the collar from the shaft. After the two sutures nearest the neck have been introduced, the passage of the others would be greatly facilitated by preserving the relative position of the parts until all have been passed. It can then be disjointed and withdrawn, as a staff, without difficulty, and the sutures secured. On referring to the plate, it will be observed that the usual pressure exerted by the instrument has been lessened for the purpose of showing its application; by so doing the parts have rolled out, and the scarified surfaces have become proportionately separated. To appreciate the condition represented, it must be borne in mind by those who are not familiar with the position, that the patient is represented as lying on the left side.

It is evident that the sulcus produced by this instrument must be very nearly in the median line, and the cervix held in position at the end of the vagina. Along the edge of the sulcus formed, a broad strip of the mucous membrane should be denuded, extending (as we have shown) from the neck of the bladder to just beyond the cervix on each side. The instrument is then removed, and the uterus drawn down with a tenaculum, for the purpose of making the transverse or connecting line of scarification, in front of the neck.

For removing the mucous membrane, I have been in the habit of using various curved scissors. As the hemorrhage is sometimes excessive, the surface can be thus removed more rapidly than with the knife.

The sutures in the tranverse section should be passed with great care, and as nearly continuous as possible. The surface



is too long a one to be embraced by a single needle, so that at each stitch, the point must be inserted again near the exit of the preceding one. Otherwise, instead of smooth surfaces being approximated, they will be brought together as by a purse string.

I have had a needle made for use in this operation, as well as for vesico vaginal fistula, short, round, and slightly curved near the point, of different lengths, which experience has demonstrated to be preferable to all others. In this form, a punctured wound is made, and with no hemorrhage, as often follows the flat needle, with a cutting edge.

It is well, immediately after the silk loops of the first sutures have been passed, to attach the silver wire and draw them through. From the length of the operation, the silk, from being so long saturated with blood, becomes weakened so that, if the passage be delayed until all have been introduced, it will often break, from the resistance in drawing it through so continuous a line. The remaining ligatures should then be passed in rotation (at an average of four or five to the inch), each skipping over the undenuded triangular space, until the apex, at the neck of the bladder, has been reached.

It is worthy of note, that the want of a uniform success in the application of silver sutures, may be attributed to the use of too small a number, the insufficient amount of tissue included by them, and to strangulation. Each suture should be passed as to the points of entrance and exit, as nearly parallel as possible to the previous one. But the same care is not so necessary in relation to the relative distance from the edge of the scarification—provided the sutures are afterwards properly secured. Reference is here made more particularly to this operation; for it is exceedingly difficult always to bring

the point of the needle out, exactly at the same distance from the edge as that of entrance on the other side. Consequently, the amount of unscarified tissue approximated with the denuded surface, must be in proportion to the difference, and either no union takes place, or to an extent insufficient to be permanent. Before twisting, this may be obviated by bending a shoulder on the suture at the same point as would correspond with that of entrance from the edge, on the opposite scarified surface. This will be more readily understood by reference to the diagram. It will be observed that the sutures (3 on one side and 4 on the other), have been bent in this manner, and what the obvious result would be, if twisted together, without this expedient.

In some cases, from fifteen to twenty sutures are required, with double the number of ends projecting from the vagina; they become tangled together and prove a source of great embarrassment to the operator, long before the requisite number have been passed. Dr. Sims' usual method was to make a number of incisions into the side of a piece of soft wood, and, in rotation, from one end to the other, each pair of sutures were embedded in a separate slit. He sometimes also used a small comb for the same purpose. The facility thus given by some such expedient can alone be appreciated by the operator, as the order is preserved, and each suture remains undisturbed, until required in turn to twist.

I prefer, however, to pass each wire through a loop made at the other end, as shown in the diagram, by the suture nearest to the neck of the bladder. It is then gently drawn through, until the looped extremity is about the necessary length to twist, and the single end is then passed behind the upper side of the speculum, to the assistant holding it. By passing the

sutures from above downwards, each is thus gotten entirely out of the way. It is true that the same order is not exactly preserved. But, by beginning to twist the sutures in turn, from below upwards, each, when needed, can be readily separated from the others by a little traction on the wire, just above its loop.

They should be twisted just sufficiently to approximate the edges, and never in the line by which they have been passed, or strangulation of the parts cannot be always avoided. Having been grasped by the forceps and drawn firmly over Sims' Fulcrum, they should be bent at nearly a right angle over it, and twisted only up to this point.

They are then to be cut off at about half an inch in length, and bent over flat, alternating to the right and left. This order is of some practical importance, as the sutures frequently become imbedded, and, if not all removed, may become, months afterwards, a source of inconvenience.

After the patient has been placed in bed, the bladder should be emptied. The after treatment is confined to giving opium in sufficient quantity to constipate the bowels, and to regulating the diet with the same view. The urine should be drawn off regularly, and, after the second or third day, the vagina carefully syringed, night and morning, with tepid water.

The sutures are generally removed from the tenth to the fourteenth day, and may be allowed even to remain longer, if a large surface has been turned in. The patient should be confined to the bed for about three weeks after the operation, and the bowels constipated, if possible, for the same length of time. After a dose of castor oil (before a movement of the bowels takes place), it is advisable to throw into the rec-

tum a few ounces of sweet oil or flax-seed mucilage. When it has been deemed judicious to remove the sutures at an earlier day, the same necessity for constipating the bowels no longer exists.

The term "narrowing the vagina," in connection with this operation, is objectionable, as only the surplus tissue is included by the sutures. The vagina is in fact only restored by the operation to its natural size. For if, by accident, the scarification is extended beyond a given point, the tension is so great that the sutures invariably cut out. The only change made from a normal condition, is the formation of a fold in front of the cervix uteri. This, however, gradually disappears, and, as we have shown (even soon after the operation), offers no impediment to the progress of labor. The parts turned in, being relieved of all tension, retract and become blended together, so that the natural thickness of the base of the bladder is gradually regained.

By the same principle, Cystocele and Rectocele (in fact often but the first stages in Procidentia) can be even more readily relieved. The form of scarification, however, is somewhat modified. For Rectocele, the form is an ellipse, extending from a point within the fourchette, as far upward as necessary. For Cystocele, the scarification is more that of an oval, and should be extended from the neck of the bladder to the cervix uteri.

In presenting this method to the profession, (a natural sequence to the previous labors of others,) it is not advocated that all cases of Procidentia should be subjected to this rather formidable operation; for it is a well known fact, that many cases of recent origin recover perfectly by rest in the recumbent position, astringent injections, and other suitable

means. But it should be resorted to beyond this point; when the uterus has become hypertrophied, and before it has remained outside of the vagina for years, unreduced; before the vagina has lost entirely its contractile power, through the usual systematic course of stretching by pessaries, each from necessity being larger than the previous one in use. After the condition has become hopeless, all efforts for relief have been abandoned, and the patient has become more or less incapacitated for the performance of her daily duties—in such cases, (so long an opprobrium to the profession,) it is believed that at length a definite result has been gained for this otherwise intractable condition.

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