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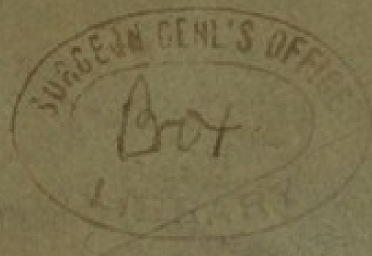




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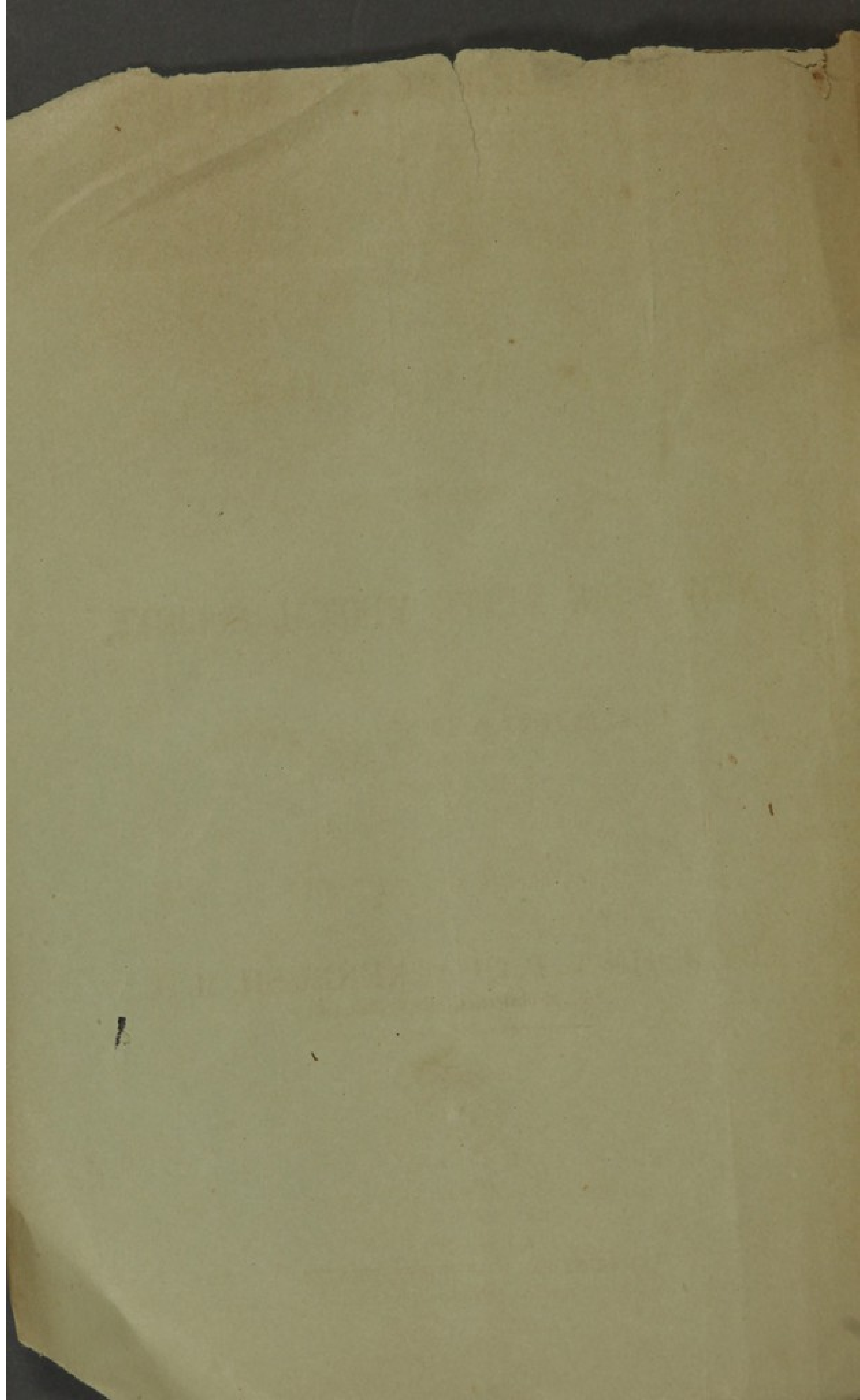

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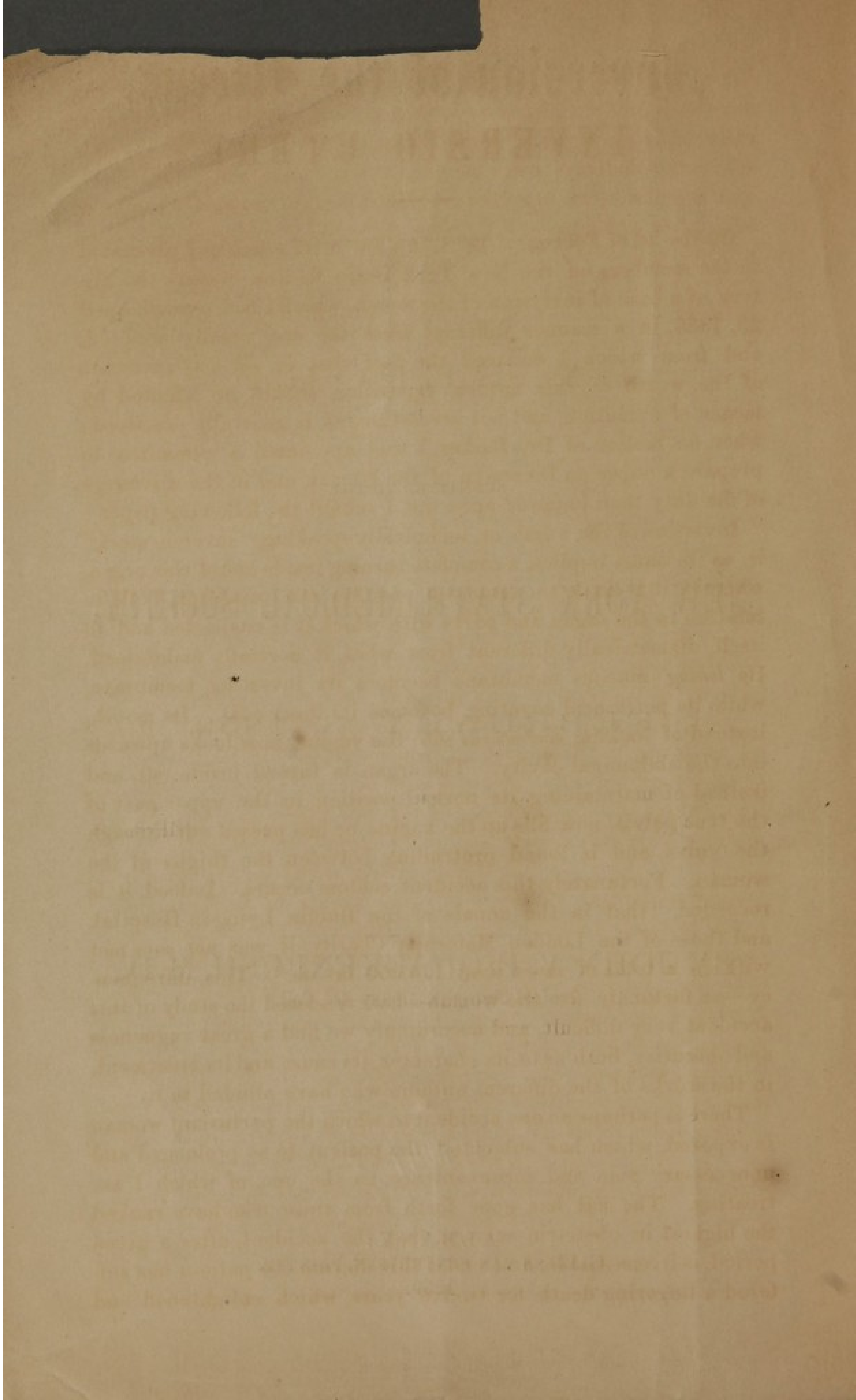

# INVERSIO UTERI.

On the 2d of February, 1858, in a few brief remarks I presented to the members of the New York State Medical Society the history of a case of inversion of the womb, which I had treated April 29, 1855, in a manner different from the one usually adopted, and from which I deduced the fact that in all displacements of the womb of this nature, reposition should be effected by means of evolution, and not involution, as is generally practiced; when on motion of Dr. Barker, I was appointed a committee to prepare a paper on Inversion of the Uterus, and in the discharge of the duty then imposed upon me, I submit the following paper:

Inversion of the womb, or, technically speaking, "inversio uteri," is, as its name implies, a complete turning inside out of this organ, whereby it is made to assume a position and condition, both in relation to the organ and parts with which it is connected and to itself, diametrically different from what it normally maintained. Its *lining* mucous membrane becomes its investing membrane, while its peritoneal covering becomes its inner coat. Its mouth, instead of looking *downwards* into the vagina, now looks upwards into the abdominal cavity. The organ is turned inside out, and instead of maintaining its normal position in the upper part of the true pelvis, now fills up the vagina, or has passed out through the vulva, and is found protruding between the thighs of the woman. Fortunately this accident seldom occurs. Indeed it is recorded, "that in the annals of the Dublin Lying-in Hospital, and those of the London Maternity Charity, it was *not once* met with in a total of more than 140,000 labors." This infrequency—so fortunate for the woman—has rendered the study of this accident very difficult, and accordingly we find a great vagueness and obscurity, both as to its character, its cause and its treatment, in the works of the different authors who have alluded to it.

There is perhaps no one accident to which the parturient woman is exposed, which has subjected the patient to so prolonged and unnecessary pain and inconvenience, as the one of which I am treating. The fiat has gone forth from those who have ranked the highest in obstetric science, that the accident, after a given period, is irremediable, and under this dictum the patient has suffered a lingering death for twelve years, which enlightened and

educated midwifery has cured in one hour. Such being the nature of the accident, it demands a prominence which it has not thus far received; and I propose making some suggestions as to its mode of treatment, and advancing some opinions as to the manner in which it occurs, which are different from those of any author whose work I have perused. These suggestions will be based on experience, and these opinions will rest on theory; for the experience of no one practitioner will enable him to teach practically the different stages of this disease, and the peculiar treatment adapted to each. We find this accident *after* it has happened, and then we adopt the treatment proper for relief; but how it occurred we cannot tell, for it had passed through its different stages ere we have been even aware of its occurrence. Did we know that inversion of the womb was about to happen, or was passing through its primary stage, we would arrest it, and therefore we would seldom, if ever, meet a case of complete inversion. From this you will perceive that the mode of its occurrence. though regarded as known and sure, and so treated by authors, is really a legitimate subject for speculation, and therefore I need offer no apology for introducing in its proper place, a theory which I have adopted, and which, at least, possesses the charm of novelty.

In presenting to you, then, this paper on Inversion of the Womb, I shall allude briefly to its causes, then speak of the manner of its occurrence, and lastly discuss its treatment; illustrating by cases *how* erroneous views of the accident have led to errors in treatment, which would have caused the death of the patient had not the recuperative powers of nature been more efficient than the destructive agency of the doctor.

This accident in almost every case occurs immediately after labor; sometimes, however, it does not become manifest for a number of days afterwards, and yet in these very cases the inversion was from the commencement probably partial, and *only* rendered complete by a strong contraction, caused by the natural evacuation of the contents of the intestines, or consequent upon the administration of an active cathartic. In some rare cases the uterus has become inverted gradually in consequence of a polypus being attached to the fundus, and thus upon its expulsion, dragging down the womb mechanically with it.

In enumerating the different causes to which authors have attributed this accident, some real and some fanciful, I shall necessarily mention some which, in my opinion, can effect little or no agency in the matter.

1st. Traction on the chord has always been regarded as a principal cause of this accident; and this, when strictly studied and understood, will account for cases attributed to other means. It is a singular fact, and very significant, too, that many cases of this kind, reported by authors on obstetrics, have occurred to women who have been attended during their labors by midwives, who, not understanding the true principles and practice of midwifery, have no doubt, injudiciously interfered with their cases, and thus produced this accident by a too severe and untimely traction of the chord. The *detachment* of the placenta should never be attempted solely by drawing on the chord; its *removal*, however, can often be accomplished in this manner, and the want of making a true distinction between the two has, without doubt, often led to the commission of this error.

2d. Quick labors are said to be instrumental in causing the accident alluded to, which of themselves I should think could have but little agency in the matter.

3d. It has been observed to follow labors where the woman has been delivered in a standing position; and,

4th. It has occurred spontaneously. The following case, given by Dr. Radford, and reported in Churchill's Works on the Diseases of Women, was given in illustration of these causes: "The subject of this accident was Mrs. Birch, of Great Bridgewater street, a well formed, healthy young woman, and this was her first confinement. I was summoned to her," he writes, "on the 17th day of May, 1826, about three o'clock in the afternoon. I found her *walking* about the room, with pains bearing down and effective. In a short time after my arrival, whilst *leaning* forward on the bed, she was delivered of a fine, healthy male child. From this position, (as soon as the child was separated,) she was removed carefully into the bed. In less than two minutes she had a slight pain or two; these were followed by a violent bearing down pain, and the uterus was found inverted and the placenta adhering to it." The author adds, "I would remark, this inversion was entirely spontaneous, as I had not even taken hold of the funis at the time it had happened." Had this woman been *lying* in bed when the child was delivered, or had it been shown that the weight of the child had exerted no traction on the funis previous to its separation, then indeed traction on the cord could have had no agency in producing the accident; but without this is shown, we must attribute it to some cause other than standing position or spontaniety.

5th. Dr. Tyler Smith regards inversion as depending upon an irregularly active condition of the uterus, by which the *fundus* is first depressed, then carried downward by the annular contraction of the uterus, and finally completely everted. This undoubtedly has a great influence, and if not the exciting, is, in many cases, the predisposing cause; but *how* this irregular contraction can produce this depression or dimpling of the fundus, which presupposes a lengthening rather than a shortening of the fibres, I am at a loss to discover. But of this I will speak in detail when I allude to the manner in which this accident occurs.

6th. Nauche considers the inactive state of the uterus and some effort made by the patient or attendant pulling the cord, as the principal causes.

7th. Henkel attributes it to violent after pains.

8th. Some authors have thought that a short funis is a frequent cause of inversion; but certainly no one can say that this can exert any influence, unless the shortness of the cord gives rise to traction.

9th. Boivin and Dugès enumerate, as among the principal causes of inversion, a flaccid distensible state of the uterine parietes; inertia of the uterus, especially if at the same time an effort be made for the extraction of the placenta; irregular uterine contractions and dragging at the cord; while,

10th. Dr. Radford, of Manchester, thinks that the circumstances attending this accident warrant him in the deduction that the fundus and body of the uterus, so far from being in a state of *collapse* or *relaxation*, are really in a state of *unnatural excitement* and *action*. Thus we see that our French brethren attribute this accident to a condition exactly the reverse of that which our English author maintains must be present.

11th. The last cause which I shall mention, and the one which, after study and reflection, I consider the true one, is this, *irregularity* of action; and by this term I do not mean an *undue* action of some of the fibres of the body and fundus, whereby a portion is drawn down or depressed, but a *want of correspondence* between the muscular action of the neck and the body of the uterus, in which there is a complete atony of the muscular fibres of the neck, which is consequently soft and yielding, and a partial action of the fibres of the body and fundus, sufficiently strong to draw it down through the patulous mouth of the womb, but not active enough to detach the placenta, which we usually find adherent. Here, then we have an atonic and patulous condition of the os

and cervix uteri, affording no impediment to the protrusion of the body and fundus, which is drawn down by the slight muscular contractions, by the traction on the cord, by the weight itself of the fundus with the placenta attached, or perhaps is *pushed* down by the superincumbent mass of intestines, aided by the contraction of the abdominal muscles. I am led to this conclusion by the fact that in numerous cases of this character the placenta remains attached to the uterus, not only after it is inverted, but even when it has protruded through the vulva, which would not not be the case if the action had been excessive, for the contractions, violent enough to produce this inverted condition of the organ, would certainly be sufficiently powerful to detach the placenta. I have thus enumerated the causes which are regarded by authors as instrumental in the production of this accident. The infrequency of its occurrence, and the suddenness with which it does occur, render it difficult to decide positively what the cause may be; and, therefore, while so much uncertainty invests *this* portion of the subject, we may certainly *speculate* as to the *manner* in which it takes place, although all authors agree that there is one method, and one only. It matters not what author we quote, the idea advanced by all is the same, although the phraseology in which it is invested may be different. I will give the manner as described by Tyler Smith:

"There is, first, cup-like depression of the fundus uteri; coincident with, or immediately following upon this depression, there is hour-glass contraction of the body or lower portion of the uterus. The annular contraction of the body of the uterus grasps the introcedent fundus as it would a foreign body, and carries it downwards for expulsion through the os uteri, the os uteri being at this time either in a state of inertia or actively dilated, just as at the end of second stage of labor. After the inverted uterus has passed through the dilated os uteri, this part of the organ becomes contracted, preventing re-inversion from taking place. Thus there is first, a depression of the fundus uteri, with annular or hour-glass contraction of the body of the uterus and dilatation of the os uteri. Next, there is intussusception of the fundus by the body of the uterus. Lastly, complete inversion occurs, with contraction of the os uteri upon the inverted organ. If we wished to describe this accident in three words, they would be, introcession—intussusception—inversion." This, then, is the *manner* in which, all authors agree, this accident takes place, whatever the cause may be—excessive contraction, or complete relaxation.

First, a mere dimpling of the fundus uteri, which finally ends in complete inversion. Now I would advance the inquiry, how can this depression be caused by contraction? Are not the fibres of the uterus lengthened when this depression occurs, and does contraction cause a lengthening of the fibres? Can we advance any more plausible theory by which we *can* account for this accident? Is there any *other* method by which the uterus *can* be inverted, than the depression of the fundus and the subsequent dragging down of the body? I think there may be, and as I said irregularity of the contraction was the cause of this accident, so I think *that* irregularity may act in the following manner: It is well known that there are two layers of fibres in the uterus, one the circular, or horizontal, the other the longitudinal layer; the former encircling as a band the os and cervix uteri, while the latter extends from this band and passes over the fundus of the uterus. When labor commences and proceeds, both these layers contract, but after a time the circular fibres yield to the more powerful action of the longitudinal, the os uteri opens, and the vagina and uterus become one continuous and regular canal. The organic contractility continues and the organ is freed from the foetus which it contained. Another contractility now comes into play. This is the contractility of the tissue, a property by which the womb, after having been emptied, returns gradually to its former state, and thereby has its cavity nearly obliterated. Now, at this stage there may be irregularity of contraction. The circular fibres, constituting a sort of spincter muscle of the womb, are relaxed and form no firm attachment for the longitudinal fibres. The longitudinal fibres, which may represent so many columns resting on this circular band as a foundation, contract, and, having no support, they begin to yield from the bottom, evolution takes place, the neck doubles in upon itself and passes through the os, the body follows and, finally, the fundus, dragged down upon the body, preserves the same course, and we now have a complete inversion. The fundus being the *last* portion inverted, instead of the first, as has been generally, or I may say, universally admitted. As I have previously mentioned, speculation presides over this portion of the subject, and when we enter her domain, probability and plausibility must conduct us, when *facts* fail to be our guide. But whatever may be the causes of this accident, and whatever may be the *manner* of its occurrence, the proper treatment is what most demands our attention; and this is the third and last point for which I will ask your consideration. And what is the proper

treatment of inversion of the uterus? I answer, reduction. If the case be recent, reduction; if of twelve days duration, reduction; if of twelve years duration, reduction! At any time, and under all circumstances, reduction must be resorted to, and very few cases will be found which arc irreducible. I lay much stress upon this subject, for I do not think it well understood. Hear what Tyler Smith says: "I cannot suppose that with proper and prompt management any case could be considered irreducible *within* a *reasonable* time after the accident." And what is the alternative he proposes? "When reposition is *impossible*, the extirpation of the inverted organ, by the dangerous operation of the ligature or excision." And now listen to the language of Dr. Meigs, who doubtless speaks the sentiments of the profession upon the subject, relative to a case which had existed for some time. "It was inverted at the time of her confinement, six months ago. Mrs. Lucina inverted it by pulling at the cord before the placenta was detached, and either did or did not know what she had done. The hæmorrhage was terrible. The woman ceased to bleed and did not die, because she fainted so badly that the vascular injection by the heart was too feeble to kill her by hæmorrhage. She slowly recovered, in a measure, but bleeds still upon the smallest excess of exercise or labor.

"Well, now my young friends," he says, for he was addressing his class, "you have made your diagnosis, what are you to do for your patient? Will you reposit or reinstate this womb? You can't! You might as well try to invert one of the non-gravid uteri on my lecture room table as to reposit this one. The time is gone by. You have no art or skill or no power equal to the performance of such a miracle of surgery as that." Gentlemen, this miracle has been done and can be done, and should be done, and with proper management no case need be abandoned. It is now understood that almost *every* case can be reduced, but no author or practitioner has proposed a method applicable to all cases. Dr. Churchill, in his admirable work on diseases of women has given the following directions, and I may add, his is the method which is generally adopted. The protruded organ should be grasped firmly, and passed in through the vaginal orifice, followed by the hand (previously well oiled,) which, when in the vaginia should be closed and formed into a cone and made to press mainly upon the fundus uteri. This was the mode adopted by Dewees, and in which he failed, and in which his many followers have also failed. And now if we study the modus operandi of this method

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we can understand why failures were so frequent. The manner of reposition is this: The uterus is carried firmly up the vagina till it, the vaginia, becomes tense, being put upon the stretch it pulls upon the os uteri and *reinverts* it, and now making a depression or dimple in the fundus, we carry it upwards, and necessarily have four layers of the uterus passing through the os uteri at the same time. The contracted os uteri resists, and the large quantity of uterine fibres present an obstacle which cannot be overcome. In reposition accomplished in this manner, the uterine tumor begins to shorten at the fundus, for that is indented and pressed in. This method then, has its objections. I would now propose a method applicable to all cases, whether they be recent or long standing, which is simple, and I think, philosophical. The inverted uterus should be grasped in the palm of the hand and compressed firmly, so as to render it less bulky, by having its quantity of blood lessened. It should now be carried up into the vagina and pressed steadily; the vagina will become tense and reinvert the mouth; steady pressure should be maintained and the uterus will continue to double upon itself; evolution takes place, the uterine tumor shortens at its *neck*, complete reinversion is effected and no depression or dimpling of the fundus is at any time perceptible; and at no time, by this method, are there more than two layers of the uterus passing through the mouth. Having treated a case of this description in this *manner*, April 29, 1855, with success and with great ease, of which I made a verbal report in February last, I take great pleasure in recommending it to this society, and while my own experience proves its applicability in recent cases, I would state that Tyler Smith, of London, and our fellow countryman, James P. White, of Buffalo, have both recorded cases, one of twelve years duration, and the other of fifteen years, treated successfully, and I may say, triumphantly, by this method. Dr. Smith Reported his case to the Royal Medical and Chirurgical Society, April 13, 1858, and Prof. White communicated an account of his case at a meeting of the Buffalo Medical Association, April 6, 1858. This, gentlemen, concludes all I have to say in relation to the nature, causes, manner of occurrence and mode of treatment of inversion of the uterus, a subject invested with much interest and some obscurity; if I have in the smallest measure added to that interest, or in the slightest degree deprived it of obscurity, I shall then think I have discharged the duty which the society imposed upon me.