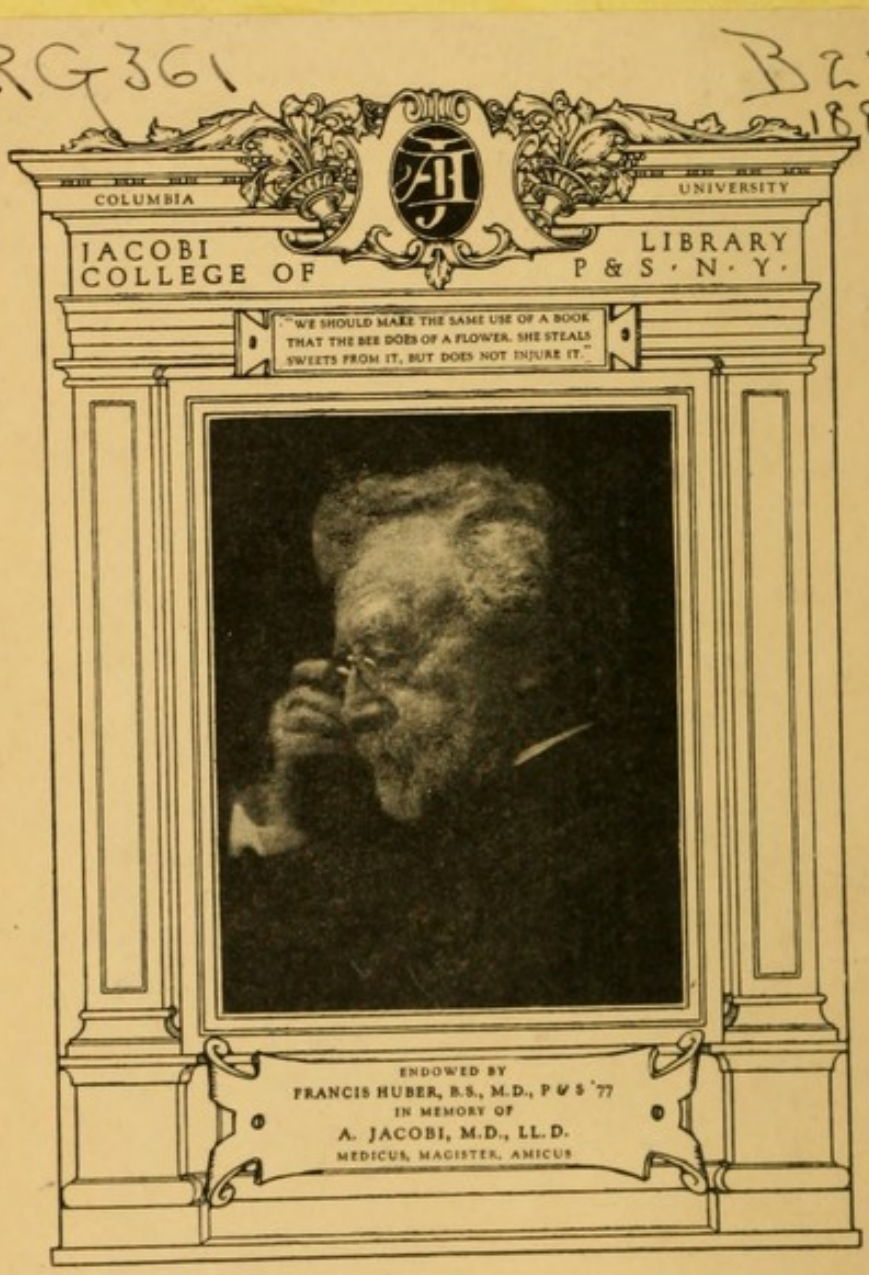
On the use and abuse of pessaries.



ON

THE USE AND ABUSE

OF

PESSARIES

BY

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PREFACE TO THE SECOND EDITION.

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The pamphlet on which this work is based first appeared as an ephemeral paper in the pages of *The Lancet*, and it was afterwards published in a separate form. It was intended as a mere sketch, and was written hastily in answer to a sort of challenge "defying all the doctors in Christendom to put right" a displaced uterus. The reception which it has met with, the voluntary testimony of numerous impartial practitioners, both special and general, as to the results obtained from a practical test of the principles and practice inculcated, and the numerous inquiries after the pamphlet since it has been out of print, have induced me to bestow a considerable amount of labour upon this edition. I have not aimed at a systematic treatment of the subject, but have preferred to handle it from a practical point of view. In this form I trust it will be more acceptable to the busy general practitioner, while the gynæcologist will find it more easy to compare the opinions and practice with his own experience. I am not unconscious of the feeling that

some of the views here advanced will meet with strenuous opposition from a section of the latter class. Some of the doctrines are now common to a great many eminent gynæcologists, and therefore are not new; others are novel and must run the gauntlet of criticism. In this I believe they will stand their ground. From a practical test, which alone is of value, I am confident they will emerge triumphant.

It only remains for me to express my thanks to Mr. Alban Doran for his valuable assistance as these pages were passing through the press, and to Dr. Junker for several of the illustrations.

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ON

THE USE AND ABUSE OF PESSARIES.

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THERE is probably no subject in the whole range of gynæcology on which so much difference of opinion exists, on which opinions are so much opposed, as that of uterine displacements. Not only do opinions differ as to the nature of these displacements, but they also differ as to the symptoms which they produce. So varied also are the views as to the value of mechanical appliances in the treatment of uterine deviations, that, while on the one hand many eminent gynæcologists regard pessaries with great favour, as very efficient means in the treatment of displacements, and the morbid conditions so frequently associated with, if not actually dependent on them, others equally eminent, but in smaller number, are as much opposed to them, and attribute to their use untold mischief.

In illustration of this conflict of opinion a few quotations will not be out of place.

Some years ago Dr. Atlee stated that he had had no experience in the introduction of pessaries, but a

large experience in their withdrawal, and that he had been able to remove the symptoms in most of his patients without the use of pessaries; and when that could not be done he was satisfied without their their use. And he went on to declare, that with the uterus and pelvic organs in a healthy state, he was of opinion that a change in the position of the uterus was of no significance whatever, and there was no need of an instrument to keep it in a certain position.

Dr. Henry Bennet says, his whole experience is antagonistic to the doctrines taught, and the treatment pursued, by those who employ mechanical means.*

Dr. Matthews Duncan, believes, there is "a fashion in these matters;" that "years ago every woman suffering from uterine disease was said to have a dislocated uterus; at a later period no one had any affection of that sort; and now again every woman was getting her uterus dislocated;" and he added this strong challenge: "I defy all the Doctors in Christendom to put it right."* Again, he considers "the morbid importance of displacement as very much exaggerated. It would be nearer the truth to say it has little or no importance."† Of pessaries all he has to say is, that he thinks "the support by a Hodge or similar vaginal pessary, of a large, tender uterus, a plan of treatment well worthy of trial."‡ He divides displace-

* British Medical Association Journal, Aug. 25, 1877, p. 259.
† Transactions Obst. Soc. of London, 1881, p. 206.
‡ Letter to *Lancet*, Feb. 2, 1878.

ments into two classes, viz: "displacement without descent, and displacement with descent." He believes "displacement without descent is, so far at least, an uncomplicated affection, introduces no new kind of disease, but a changed set of conditions not so simple as those of displacement with descent."*

Scanzoni says, that "Flexions (under which head he also includes Versions) do not acquire any importance, nor are followed by any serious dangers save when they are complicated with an alteration in the texture of the organ." He then goes on to discuss the question "How and why flexion eventually *almost necessarily* induces alterations in the structure of the organ."†

Bernutz writes thus:—"It has been my aim to prove that deviations of the uterus *when simple*, with the exception of prolapsus and procidentia do not cause any functional disturbance, but when complicated with old pelvi-peritonitis, or uterine catarrh, or congestion, the faulty position and the abnormal mobility of the uterus are a source of pain, and demand treatment."‡

On the other hand Barnes, Graily Hewitt, the two Simpsons, Edis, Atthill, Angus Macdonald, Hart and Barbour, and others in this country; Sims, Thomas, Emmet, Albert Smith, Goodell, Lusk, Mundé and a host of others in America;

* Obst. Soc. Trans., *loc. cit.*

† On the Diseases of Females, by Scanzoni. Gardner's transl. p. 115.

‡ Diseases of Women, Bernutz and Goupil. Syd. Soc. transl. p. 231.

and in Germany, Hegar and Kaltenbach, Fritsch (Halle), Schultze, Winckel (Dresden), Amann (Munich), and others, all maintain the importance of uterine displacements, and the necessity for their treatment by mechanical appliances. A distinguished American recently said to me in discussing this question, "In my country this question is now settled, and no one worthy of consideration thinks of disputing the value of properly adapted pessaries." This paragraph would be incomplete without mention of the case of Dr. Angus Macdonald, to whom I referred a few years ago, in a speech delivered before the Obstetrical Society of London, in these words :—"Not long ago Dr. Angus Macdonald related a most instructive case, in which, after exhausting all the modes of constitutional and topical medication, on which Scanzoni and others would have relied, in vain efforts to relieve his patient, he was obliged to have recourse to a pessary. The result was a complete success. At the same time he took occasion to confess, with a courage which all must admire, that, though he had begun practice strongly disposed to disregard uterine displacements, this case convinced him that he was bound to reconsider his position, and to recognise not only the importance of displacements as a cause of suffering, but also the value of the pessary as a means of relief." I have reason to know that Dr. Macdonald is now a firm believer in the necessity for, and the value of, the pessary.

An attempt to reconcile these conflicting views,

or to explain them away would be a hopeless task, but it will not be without use if I pass in review the statements and opinions of those who take the negative side.

When Dr. Atlee admits that he has had no experience in the introduction of pessaries, he cannot fairly discuss their use and abuse; and when he says that with the uterus and pelvic organs in a healthy condition (and I would add, as a necessary corollary, with the patient free from symptoms) a change in the position of the organ is of no significance whatever, he states a self-evident proposition. Many discussions have taken place on this subject, but I am unable to recall a single instance of any one contesting this point. For: What is the object of all treatment? It is to relieve symptoms, and the relief of symptoms is the measure of the efficacy of all treatment. A man with a dislocated shoulder, which did not interfere with the full use of his arm would not trouble himself about reduction, any more than a woman with a dislocated uterus, which produced no symptoms, would apply for relief. But experience shows that a man with a dislocated shoulder does suffer great inconvenience; and it also shows that a woman with a dislocated uterus is no more exempt. How is it that women with well marked anteflexion so frequently complain of dysmenorrhœa, that they are so often barren (if married), that the use of a stem pessary relieves the dysmenorrhœa and so often brings about fertility? How is it that in a case of anteflexion with con-

striction of the internal os, severe dysmenorrhœa, and barrenness, the division of the cervix without any other treatment produces the same results? How is it that retroversion is so often found associated with barrenness, and more often is the cause of repeated abortions? How is it that a woman who complains of a tolerably definite and regular train of symptoms is found to be the subject of a retroversion of the uterus, and that the rectification of the uterus removes the symptoms, renders her fertile, and enables her to go to her full time? How is it that a woman, who has been the subject of menorrhagia, after bearing one or more children, gets rid of her menorrhagia by no other treatment than the introduction of a properly-fitting pessary? Are all these *facts*, which will be illustrated in the course of this work, consistent with the idea that displacement of the uterus is of no importance? Is it only an effort of the imagination when we describe a case of this kind; namely, that a woman who walks or hobbles into our consulting room, or lives a life of chronic invalidism, complaining of pain in the sacral region, and an indefinable feeling of "bearing down" in the pelvis, which interferes with her walking, is aggravated by a fæcal evacuation, and renders irksome, if it does not prohibit, sexual relations, in a few minutes after the application of a pessary walks with comfort, tells us she is now free from pain, and subsequently finds that she can discharge all her duties with satisfaction? Surely,

we have not been living in a fool's paradise all this time!

Dr. Henry Bennet's statements are of too general a character to analyse, and amount only to assertion.

More definite are those of Dr. Matthews Duncan, who recognises two forms of displacement—viz., "displacement with descent, and displacement without descent," the latter of which he regards as "of no importance whatever." Whatever importance is to be attached to this descent in the case of backward displacement, it can have none in that of, say anteflexion, in which there is no descent of an appreciable amount, in the great majority of cases; and yet these cases of anteflexion are the most productive of symptoms and disabilities. Dr. Duncan believes that in displacement with descent the symptoms are due to the dragging on the broad ligaments. In anteflexion there can be none of this dragging. On the other hand, in the case of retroversion and retroflexion, as Dr. Graily Hewitt* pointed out, this descent "forms an essential part of the disorder." This has been demonstrated in the most exact manner by Dr. Berry Hart. In the case of retroversion we find not only a descent of the cervix in the vagina, but also a descent of the body into Douglas's pouch. Hence the dragging pains in the sacral and lumbar regions, together with dislocation of the ovaries, accompanied by inevitable discomfort under various circumstances, such as fæcal evacuation, sexual relations, &c. This descent

* Trans. Obst. Soc., *loc. cit.*

is very pointedly noticed in the recently published work of Hart and Barbour, in these words: "On vaginal examination the cervix is low down in the pelvis;"* and again, "we observe clinically that it (the cervix) is much more easily reached. This is partly due to the alteration in its direction and position (being nearer the symphysis pubis, it is more within reach), partly to the sinking down of the uterus as a whole in the pelvis."† Of the correctness of this description any one may satisfy himself by direct measurement in a case of retroversion by first measuring the distance of the os uteri from the vaginal outlet in the retroverted state, and then after replacement of the organ into its natural position, and especially after the adaptation of a pessary.

Dr. Duncan's treatment of retroversion or retroflexion is probably in accordance with his views of the pathology; yet he admits that he thinks "the support by a Hodge or similar vaginal pessary, of a large, tender uterus, a plan of treatment well worthy of trial."‡

When Scanzoni affirms that flexions (and versions) do not acquire any importance, nor are followed by any serious dangers (symptoms ?) except when they are complicated with an alteration in the texture of the organ, he fails to be consistent with himself when he goes on to discuss the question "How and why flexion eventually almost necessarily induces alterations in the structure of the organ." After

* Manual of Gynecology. Chapter—Retroversion, p. 332.

† *Op. cit.* Chapter—Retroflexion, p. 334.

‡ See p. 2.

such an implied admission it seems needless to pursue this part of the subject further.

Bernutz says, "It has been my aim to prove that deviations of the uterus, *when simple*, with the exception of prolapsus and procidentia, do not cause any functional disturbance." How far M. Bernutz has proved his case I leave to the reader to determine. It is a remarkable fact that women who are the subjects of prolapsus or procidentia complain more of the discomfort arising from the inability to micturate freely, or from the presence of the prolapsed organ between the thighs, and the consequent irritation of the exposed parts, than anything else. He admits that when the organ is "the seat of chronic catarrh or congestion, the faulty position and abnormal mobility of the uterus are a source of pain, and demand treatment." He ignores the effect of the displacement in the causation of these morbid conditions. In this he may be left to the refutation of Scanzoni.

In a recent number of the *Zeitschrift für Geburtshülfe und Gynäkologie*, and in an article on the subject of vomiting in pregnancy by Dr. M. Horwitz, of St. Petersburg, the following sentences occur:—"The epoch in gynæcology in which versions and flexions of the uterus were regarded as in themselves something very serious and pathological is long gone by: the gynæcologist of the present day looks upon the question from quite a different standpoint. Every version or flexion of the uterus is only pathological when it is

the result of decided alteration in the parenchyma of the organ."* The author must have been ignorant of the views of all the leading gynæcologists of America, and of not a few in this country, who maintain the importance of displacements as such. Does he ignore the very serious nature of retroversion of the gravid uterus, and maintain that the displacement in this case is not pathological? According to his view also an acute or traumatic retroversion is not pathological. By parity of reasoning, a hernia of intestine is not pathological.

It will now be convenient to present a few cases illustrating the foregoing comments.

Case I.—*Retroversion of many years' standing; prolapsus of left ovary; Hodge's pessary. Cure.*

Some years ago I was asked by a medical friend to see his wife, who for months had been almost confined to her bed. She had had two children, and had never been well since her last confinement. I was told that she had been for several months, without any benefit, under the care of a distinguished gynæcologist, who neither believes in the importance of displacement nor in the value of the pessary, and it will readily be accepted that the suggestion of a pessary was made in vain. On examination I found the uterus very large, mea-

* Ueber das unstillbare Erbrechen der Schwangeren. Von Prof. Dr. M. Horwitz, St. Petersburg. Zeitschrift für Geburtshülfe und Gynäkologie, IX. Band, I. Heft, 1883. p. 138.

suring about three inches-and-a-half in its cavity, and so retroverted that the os uteri pointed to the upper part of the vaginal outlet (as the patient lay in the dorsal position). The left ovary could be felt very distinctly prolapsed into the left side of the utero-rectal sac, and was very tender to the touch. The right could also be felt on bimanual examination scarcely lower than its normal position. For many months the patient had done little more than pass from her bedroom, usually in the evening, to the couch in the sitting-room, as the erect position or the act of walking caused her so much pain. There was no leucorrhœa nor excoriation, nor could I find any cause for the symptoms other than the retroversion of the uterus and the *consequent* prolapsus of the left ovary. I at once replaced the uterus by means of the sound, the ovary at the same time resuming its normal position, and, while it was thus kept in position, introduced a Hodge's pessary. The sound indicated, by its falling to one side, that the pessary was not efficient. I therefore withdrew it and introduced a larger instrument, with a satisfactory result. The ovary was no longer prolapsed. I asked her to get out of bed while we left the room, and try the effect. This she did with a sense of great relief, and I bade her good-bye, recommending her not to exert herself much for a few days. I remained a short time in conversation with her husband, and before leaving the house had the satisfaction of seeing her walk into the room, when she expressed her delight at the prompt success of the

treatment. Beyond this, nothing was done except the administration of an occasional dose of a saline chalybeate aperient. The patient came to my house (a distance of four miles) in order that I might be satisfied as to her condition. After about a year the instrument was removed, and the uterus and ovary were left in normal position. The patient has continued quite well to this day.

The question naturally arises, why did her former medical attendant, a man of great fame and experience, afford this patient no relief? The answer comes that he both failed to recognise the importance of the displacement, and was not aware of the value of the pessary.

Case II.—*Retroversion with menorrhagia; Hodge's pessary. Cure of menorrhagia.*

In 1871, Mrs. B—— came under my care suffering from severe menorrhagia and dysmenorrhœa, for which she had been under medical treatment for several months. She complained of constant pain, more or less severe, which so interfered with her walking, that it was with great difficulty she made her way to the out-patient department of the Samaritan Free Hospital. Menstruation was excessive in quantity and duration. I found the uterus very much retroverted, its body enlarged and the cavity measuring $3\frac{3}{4}$ inches. The organ was readily replaced by means of the sound, but at once fell back on removing the support. There was tenderness

of the body on bimanual pressure, great tenderness on pressing the sound against the fundus, and a little blood followed the use of this instrument. I at once adjusted a Hodge's pessary with my usual precautions, and the patient went home in great comfort, with a prescription for tincture of the muriate of iron and liquid extract of ergot in ten mimim doses three times daily. She wore the instrument for about nine months, during which time she was able to attend to her household duties: the periods gradually assumed the normal character, assisted, as I believe, by the use of two sponge tents, and I removed the instrument. When last seen she was quite well.

Case III.—*Retroversion; severe menorrhagia; Hodge's pessary; subsequent pregnancy.*

Mrs. D——, aged thirty-three, came under my care at the Samaritan Free Hospital, in the summer of 1875, the subject of severe menorrhagia, which told its tale in her anxious appearance, and from which she had suffered since her last (sixth) confinement, a year and a half previously. She also complained of a constant bearing-down, and stated that the loss of blood was very great, and that she was scarcely a week free from a hæmorrhagic discharge. I prescribed iron and ergot. A few days afterwards I was requested to visit her at her own home, and so great was the loss that I at first

thought I had to do with a case of abortion. I then found the uterus very much retroverted, and prescribed 10 grains of gallic acid every two hours. As soon as possible she was admitted into the Hospital, and on the same day I adjusted a Hodge's pessary. This gave immediate relief to the bearing-down. I kept her in bed for about a fortnight, administering iron and ergot three times a-day, with the result of procuring her an interval of nearly three weeks, and a moderate flow. I then dismissed her. She returned on November 9th, stating that the menses were regular and not excessive in quantity, the flow lasting eight days "off and on." She complained of some discomfort in the left groin. The uterus was in good position, well supported by the pessary; the bowels were constipated, and she had frequent headaches. I prescribed quinine and iron, and a mild aperient at bedtime. On December 7th I substituted for this a saline chalybeate, with such effect that by January 25th, 1876, she was free from symptoms. The last period continued for seven days and was moderate in quantity. After an interval of three weeks, namely, on February 11th, she again returned, complaining of aching in the pelvic region, and bearing-down, and stated that she had "gone over her time." I kept her under observation till May 2nd, when I was satisfied that she was pregnant, and on the 23rd I removed the instrument. She was confined on September 25th. *No return of the retroversion or menorrhagia.*

Case IV.—*Frequent abortions, due to retroversion; menorrhagia; Hodge's pessary; subsequent pregnancy.*

Mrs. H——, aged twenty-four, married eighteen months, consulted me on October 9th, 1872, on account of menorrhagia and frequent miscarriages, of which she had had three—the first at three months, the second at four months, and the third at two months. She complained of a feeling of weight in the sacrum and hypogastrium, increased by exertion. The menses were very free, lasting eight days, and were much more abundant than before marriage. The patient, moreover, was anxious in appearance. I found the uterus retroverted; os open; uterine tissues generally flabby; slight leucorrhœa. A Hodge's pessary was adjusted and kept the uterus in excellent position: iron and ergot were prescribed.

Nov. 9th. Uterus in good position, admitting sound readily in normal direction. I recommended her to continue the treatment, and to let me know should she miss a period.

January 8th, 1873. Stated that she had last menstruated in the last week of November, and for the last few days had been sick in the morning, and had felt some bearing-down on standing. I found the pessary lying across the vagina, but the uterus still in position. I withdrew the instrument, and while the patient was in the knee-shoulder position I replaced it. It will suffice to say that on

January 26th she had a slight hæmorrhagic discharge; that on February 10th I substituted (with immediate relief to pain in the sacral region on standing), a larger instrument, as the uterus was rather low in the pelvis: that from the 24th to the 27th she was again threatened with abortion: that I removed the instrument on May 22nd, and that the patient was confined on September 3rd, under the care of Dr. Baxter Forman, of Stoke Newington. She made a good recovery.

1884. This patient has now a numerous family and has had no return of the retroversion.

Case V.—*Retroversion with attendant symptoms; pessary; pregnancy. Cure.*

Mrs. S——, aged twenty-seven, the mother of six children, of which the last was born on September 20th, 1875, came under my care on April 3rd, 1876, stating that since her last confinement she had suffered from severe bearing-down and pain in the hypogastrium, for which she had been continuously under treatment, but without relief. The bowels were costive, evacuations painful, and sexual relations intolerable. I found the uterus retroverted, the fundus and body tender on pressure (in the act of elevating with the finger), and the os open so as to admit the tip of the finger; no excoriation and very little leucorrhœa. A Hodge's pessary gave immediate relief, and the patient walked home in comfort. I prescribed also a saline

chalybeate aperient. On the 5th she returned, saying she was *perfectly free from pain in walking, and had no bearing-down.* On July 1st I removed the pessary as an experiment, and though the time was in my opinion too short, the uterus remained in good position. She returned on the 8th with the uterus again retroverted and a recurrence of the old symptoms. I re-introduced the pessary with the same result as before. On September 18th the sound entered readily in the normal direction, and there were no symptoms. On November 14th she stated that she had missed her period by four days, and for several days had had morning sickness. On March 19th, 1876, I removed the pessary, and on July 20th I attended the patient in her confinement. She made an excellent recovery. The retroversion has not returned.

Case VI.—*Retroversion; repeated miscarriages; severe bearing-down, &c.; pessary; birth of a double monster. Cure.*

Mrs. S——, the subject of repeated miscarriages, was sent to me by a neighbouring practitioner, by whom she was supposed (from her symptoms) to be suffering from prolapsus. The case was one of retroversion, and was at once relieved by a Hodge's pessary. About a month afterwards, through violent exertion in lifting, the instrument was expelled and her old symptoms returned. I re-

introduced the pessary. She became pregnant some months after. The instrument was worn till she entered the fifth month, and the patient was somewhat prematurely delivered of a double monster, which is now in the Museum of the Obstetrical Society.

Case VII.—*Retroversion with sub-involution; pessary; pregnancy.*

Mrs. C——, aged twenty-one, was sent to me on August 17th, 1882, by Dr. Playfair, of Bromley. She had had two children at full time, and a five months' abortion (on June 23rd, 1881). Ever since last confinement she had complained of bearing-down, and felt on sitting as if something were being "pushed up" her "body." Menstruation had only once occurred since she weaned her baby eight weeks previously. It was then very free, and she had great pain for several days before, and during the flow. The uterus was retroverted, very tender; lips everted, red, excoriated. The appetite was very bad, and the bowels were irritable (chiefly rectal irritation). I ordered her at once to use the hot douche, and prescribed Ammon. Chloridi gr. 10, Extr. Ergotæ Liq. ♏ 20, three times a-day, and complete rest.

October 14th.—Since visit has been "unwell" every fortnight, for four or five days, flow very free, numerous clots, great pain, increasing towards the end. Still complains of the bearing-down in the intervals.

No leucorrhœa to speak of. Bowels still irritable. Uterus still retroverted, large and tender. It was now evident that the uterus wanted support, and I accordingly adjusted a (No. 7) Hodge's pessary and ordered her to continue the douche. I also increased the dose of Ammonium Chloride to gr. 15. *24th.* The instrument got displaced about four days ago, and the patient withdrew it and replaced it up-side down. The uterus is now almost anteverted. Introduced a No. 6, so as not to push the cervix too far back. Uterus still tender. Bowels constipated. To continue the treatment, with the addition of a dose of Hunyadi János when required.

January 31st, 1883.—About a month ago patient removed the instrument as she thought it was somewhat displaced. Last menstruation, which ceased a week ago, continued over a fortnight with a great deal of pain. Uterus in very good position and smaller, but still tender. Ordered a more complete observance of instructions as to rest.

May 24th.—Has not menstruated for three months. Uterus pregnant, in good position.

Case VIII.—*Retroversion; subinvolution; menorrhagia; Hodge's pessary for two years. Cure.*

On January 28th, 1882, I was consulted by Mrs. G——, aged thirty-one, mother of four children, the last four-and-a-half months old. She complained of great pain in the pelvic region, excessive men-

struation, debility and dyspnœa, and an irritable condition of the bowels. Menstruation irregular, interval varying from two to three weeks; flow lasting for eight to ten days, and requiring from twenty to thirty napkins: pain worst at the beginning. More or less constant discharge, usually yellowish-white, somewhat brownish. Appetite variable, tongue clean, frequent calls to stool but no diarrhœa. Patient looked anxious, there was a slight hæmic murmur, and she complained of shortness of breath on exertion.

On examination the uterus was found very much retroverted, os large and open, pointing in the axis of the vagina; the sound entered very readily with the concavity backwards, and having gone just over three inches without touching the fundus I hastily withdrew it, fearing she might have been pregnant, as she was getting near the time of her next period. The uterus being very firm I was able to replace it by backward pressure on the cervix, and adjusted a No. 8 Hodge's pessary without using the sound. Prescribed Tr. Fer. Mur. P. E. ♏ 10, Tr. Nucis Vom. ♏ 5, three times a day.

February 14th.—Menstruation came on the day after her visit and continued for a week, not quite so free as before, only about a dozen napkins; a few small clots; paroxysmal pains, but missed the pain at commencement of flow, os admitting the tip of index finger, feels granular, uterus in very good position. A little milky-looking discharge in vagina. Some irritability of rectum still. To take Fer. Sulph.

gr. 2, Magn. Sulph. gr. 30, Acid. Sulph. Dil. ♏ 5, three times a day, and to use the hot douche.

July 19th.—Feeling altogether better, has no discomfort of any kind. Menses regular, fair quantity—4 to 5 days' duration. Has not been taking the medicine at all regularly. Bowels regular.

November 2nd.—Thinks she is "quite right;" no pain, no discharge; feels nothing of instrument; uterus somewhat anteverted, menstruation regular, normal.

March 13th, 1883.—Condition so satisfactory that I removed the pessary.

April 27th.—As the position of the uterus was such that I feared it might again become retroverted, I re-applied the same pessary, after slightly shortening it.

June 2nd.—Has nothing particular to complain of: feels quite comfortable as regards the instrument.

January 22nd, 1884.—Has not been feeling well for six weeks or so, complains of loss of appetite, debility, and some dyspepsia. Menses quite regular, nothing to complain of in that respect; uterus somewhat antevered, os normal size, uterine cavity measures 2½ inches. Removed the pessary and the uterus appeared to be firmly set in its position, exhibiting no tendency to retroversion. Instrument quite clean: no vaginal discharge.

Case IX.—*Vaginismus ; retroversion ; Hodge's pessary. Cure of Vaginismus ; pregnancy.*

Mrs. C——, aged twenty-four, consulted me on September 27th, 1881. Suffered from vaginismus when first married, yet became pregnant within two months, and was confined on April 24th. On resumption of marital relations experienced the same difficulty. The husband now also complains. Menses regular, with a great deal of pain the first two days. The rectum was loaded with hard fæces, and the uterus was retroverted. I had to be contented with simply dilating the vagina, forcibly with the fingers, and prescribing an aperient.

October 4th.—Complaining of backache ; the rectum being now clear, I introduced a No. 6 Hodge's pessary.

October 11th.—Feeling very comfortable, "would not know the instrument was in."

October 25th.—No backache nor bearing-down. Sound enters the uterus in normal direction. Very little vaginismus now.

November 22nd.—Feels quite well, but at times intercourse is not absolutely free from discomfort. She says, "It is nothing to speak of now."

January 10th, 1882.—Vaginismus has *completely* disappeared. Uterus and instrument in excellent position. Menstruated a few days ago, and had no pain to speak of. Husband has accompanied her, to express his gratitude for the relief given to himself and his wife.

March 21st.—Has no discomfort or inconvenience of any kind. Has not menstruated since January 8th. Evidently pregnant.

Case X.—*Retroversion; Hodge's pessary; subsequent pregnancy in a recently married woman.*

Mrs. B——, aged thirty-nine, came under my care at the Samaritan Free Hospital in February, 1873. Had been only recently married, and was complaining of bearing-down, which had come on since her marriage. I found that this was due to a *Retroversion*, and I introduced a pessary, which at once gave her relief. After a few weeks I dismissed her, and had forgotten her case. About twelve months afterwards she returned, wishing to know why she had missed her period. I was careful not to use the sound, and merely satisfied myself by slight examination as to the position of the pessary. The patient had no complaint to make of pain or discomfort, and the instrument did not interfere with her in any way. It turned out she was pregnant. In the course of the fifth month I removed the instrument, which was—after about eighteen months—as clean as if she had worn it for only a day or two. In due course she was delivered of a living child, which, however, survived only a short time.

Case XI.—*Retroversion, &c.; Hodge's pessary. Cure. Subsequent pregnancies.*

Mrs. W——, consulted me on December 4th, 1877. She stated that she had had three children, the last a year ago, and a miscarriage at about fifth week in August last. Menses irregular—every three to five weeks—with pain in the bottom of the back. Complains of a constant bearing-down, aggravated by exertion.

On examination I found the uterus retroverted, os low down, and pointing to the vaginal orifice. The uterus was easily replaced, and a Hodge's pessary supported it well, giving the patient much relief.

7th.—Instrument threatens to come out on straining. Now, however, in good position, and sound enters in normal direction. Removed instrument, widened it anteriorly to meet the enlargement of vaginal orifice, and replaced it.

11th.—No discomfort of any kind, and is not aware of the presence of the instrument. Bowels very costive. To take Mixture Fer. Sulph. and Magnesia. (Formula p. 21.)

July 31st, 1878.—Instrument was removed a month ago, and the uterus now retains its normal position. Menstruated last on June 18th.

It would be easy, were it not tedious, to multiply these cases. I think I have sufficiently proved my

case so far, and I now proceed to develop the subject further.

Retroversion in the virgin or unmarried woman is very uncommon. Its successful treatment is also difficult; yet if uncomplicated by pelvic peritonitis resulting in adhesions, I believe it to be well within the means of cure. Whatever may be the etiology of some of these cases—whether due to error in development, or morbid conditions within the pelvis or vagina—it is certain that some are due to direct violence, such as falling on the buttocks, or (as in the cases to be recorded) from falling on the face. Such cases are attended with well-marked symptoms at the occurrence of the displacement; while the others resemble the more common instances occurring in the fertile woman, in often presenting no symptoms until congestion or disturbance of function has been set up.

The following cases illustrate the acute or traumatic form :—

Case XII.—*Acute retroversion with symptoms simulating pregnancy; Hodge's pessary. Cure. Death four years later from malignant disease of left ovary.*

Mrs. O——, aged thirty-three, was under my care during her first pregnancy. She suffered during the whole period from very distressing sickness and heartburn, for which the usual remedies, such as bismuth, soda, hydrocyanic acid, bromide of potass-

ium, &c., were tried in vain. I delivered her (by forceps) at full time of a very large and well-nourished male child in August, 1877. The sickness ceased with the birth of the child, but the heartburn continued for a few days. She made a very good recovery, regained her normal health, and suckled the baby for the usual period.

Soon after weaning her baby the menses re-appeared and recurred with regularity, though rather more abundantly than formerly. She menstruated from October 8th to 12th, 1876, as usual. On the 14th she carried a rather heavy child, five years and a half old, very hurriedly up two flights of stairs, but felt nothing more than what might be expected from such severe and unusual exertion. The next day she felt sick on getting up in the morning, and shortly afterwards the sickness assumed the same form as in her pregnancy of the preceding year. I saw her on the 16th, but for another object, and she omitted to say anything about the sickness. She then went to the seaside, and on her return I saw her again on November 2nd. The sickness and heartburn had then assumed their old proportions, and I again tried some of the usual remedies. She had menstruated at the usual period, but she thought there was a difference, inasmuch as for two or three days the flow ceased during the night and returned in the morning after getting up.

Finding the medical treatment of no avail, the patient affirming with confidence that she was pregnant, I got her consent to try the effect of local

treatment. At that time two methods were before the profession, the application of nitrate of silver to the os, as practised by Dr. Jones of Chicago ; and the dilatation of the os and cervix, introduced by Dr. Copeman. The high recommendation of the former by so distinguished an authority as Dr. Marion Sims determined the choice of this method. Through the speculum the cervix was seen to be very congested, the os was patent, and the mucous membrane turgid, and a glairy discharge issued from it. I applied the fused nitrate, by means of my probe, to the circle of the os and a portion of the cervix. Up to this time of the day the sickness and heartburn had been very distressing. Next day she told me the effect had been almost instantaneous, for on getting up again about an hour after the application, she felt perfectly well, and she had had no return. For three days this immunity continued, but on the fourth day the sickness returned, though in diminished intensity. For a day or two there was a slight hæmorrhagic discharge. The application was repeated on the 25th, and again on December 5th, but with less effect. After these two applications there was no hæmorrhagic discharge.

The menses re-appeared after the usual interval ; but the flow was of the same "dodging" character as on the last occasion. On digital examination I found the uterus enlarged, os patulous, and body enlarged, but I could not satisfy myself at this early period as to the existence of pregnancy or not.

I now thought the vomiting, &c., might be kept

up by the version, and accordingly adjusted a Hodge's pessary, placing the patient, for this purpose, in the knee-shoulder position. In this way I was able, by pressing the cervix backwards, to rectify the position of the uterus. On placing the patient on her back, after the introduction of the pessary, I found that the cervix maintained its normal position. The result of this was that the sickness was much relieved at once, and soon afterwards entirely ceased.

I now saw the patient only at long intervals, and she appeared to be advancing in pregnancy. She was conscious of progressive increase in size, and felt convinced of her pregnancy. Nor did her friends fail to notice her condition. I told her at the last mentioned date that the pessary would have to be worn for about three months. Meeting her about the middle of March, I was told that she had removed the pessary, and had continued regular, and that she was entirely free from sickness or heartburn. My suspicions were now aroused, though her appearance did not support this feeling, and I asked her to call upon me. This she did on April 1st, expressing the hope that I was not going to make an "April fool" of her. It was my duty, after examination, to tell her that she was *not* pregnant. The uterus was again retroverted, though not so much as before; the os had contracted to a more normal size, and the body was decidedly smaller, the cavity measuring about $2\frac{3}{4}$ inches. There was certainly no fœtus there, nor was there

any question of extra-uterine fœtation. There was nothing to be discovered in the abdomen or pelvis of an abnormal character, and the mammary areolæ confirmed the diagnosis. The impact of the sound on the fundus caused her some pain. The uterus was replaced with the sound; a Hodge's pessary was introduced and ascertained to be efficient. On April 7th she told me that two days after her visit she was sick in the morning, that she had had sensations in her breast similar to the "draught;" that, moreover, she had been able to squeeze a drop or two of milk out of the nipples; that she was as large as ever, and that her friends and several monthly nurses were convinced (!) the doctor was in error; one of the latter in her superior wisdom, and, after calling attention to her peculiarities of shape, affirming that if ever she saw a pregnant woman my patient was that one.

The result of wearing the pessary for some months more was that the patient got rid of the distension, as well as all gastric disturbance. The uterus retained its normal position, as proved by the use of the sound, and menstruation went on regularly and well. The instrument was removed in September, 1880.

On March 1st, 1881, the patient was complaining of pain in the left groin, and discomfort generally in the pelvis. The uterus was in a very good position and direction, the left ovary was as large as a hen's egg, tender to the touch. No menstrual trouble to speak of.

On April 22nd, she reported that two days after her last visit she was seized with an attack of sickness, with severe epigastric pain and vomiting of a greenish fluid for three days. She complained of pain in the left hip, thigh, and leg, aggravated by walking. The left ovary was still large and tender.

I did not see the patient again till September 3rd, when the pelvic examination revealed a very serious state of things. The uterus was depressed, the os was open, and the whole organ was pushed forward and fixed; behind the cervix a small round hard knob bulged into the vagina, and was connected intimately with a confused mass which filled up Douglas's pouch, spreading to each side of the pelvis and immovable. There was considerable tenderness on pressure. She complained of a constant feeling of pressure, and desire to go to stool, shooting pains in both groins and in the vagina, and frequent micturition.

It was now only too evident that the disease was of a malignant nature, and this opinion was subsequently confirmed by the appearance of disseminated nodules in the abdomen—probably in the omentum. Constipation became very troublesome, emaciation rapidly set in, and in a few months the poor patient's sufferings terminated in death.

That this was a case of acute retroversion there can, I think, be no doubt. Up to October 14th the patient was, as far as she knew, perfectly well. She rushes up two flights of stairs with a heavy

screaming child hanging on her neck, and within twenty-four hours begins to have sickness. What further evidence do we require to establish the relation of cause and effect? I confess I am satisfied. On the other hand we have also the evidence that the replacement of the organ was followed by a cessation of the sickness.

Case XIII.—*Acute retroversion from falling on the face; Hodge's pessary. Cure.*

Miss S——, aged fifteen-and-a-half, came under my care on March 17th, 1879. Menstruation began in July, 1877, and continued regular and without pain, except the first time. On January 28th, 1879, while stooping down to pick something off the floor she was seized with a fit of sneezing in which she fell prone on the floor. As she fell, she felt as "if something had given way in the bottom of the back," in the region of the coccyx. She was unable to rise without assistance, and when she got up, so great was the pain that she was obliged to lie down. This pain gradually passed off with rest. At her next period, in the first and second weeks of February she was obliged to keep her bed on account of the pain. This pain was abdominal and hypogastric. After that period she could not sit upright without discomfort, and on rising from her chair she had to assist herself with her hands. The pain was now referred to the coccyx. A careful

examination of this part failed to detect anything wrong; there was no tenderness even when roughly handled. I therefore made a vaginal examination and found the uterus retroverted, and I could not but attribute the symptoms to this. After replacing the organ by means of the sound I introduced a No. 4 Hodge's pessary, with the result that the uterus retained its position, supporting the weight of the sound. After sitting down for a few minutes she found she could rise with much less discomfort, and without the help of her arms. The replacing of the uterus caused an aching sensation in the hypogastrium for a few minutes. On March 21st she reached for something over head, and suddenly felt a pain in the bottom of the back. Up to this time she had been quite comfortable, and had almost forgotten that she had had anything wrong—and, certainly, she had forgotten my instructions, or deemed she was no longer under the necessity of observing them. Since then she had had more or less discomfort—though much less than formerly, and she could rise from her chair in the ordinary way. She had none on sitting down. On examination, the pessary was found too loose in the vagina, and I substituted a No. 5. This gave her so much relief, that on rising from her chair she was just conscious of "something not quite right," as she expressed it. The last period was from the 6th to 10th and was *quite painless.*

November 4th.—Patient feeling quite well. I removed the instrument to find that the uterus was in

its normal position. Since last visit the periods have been quite regular, and without anything more than *a little aching*, such as she used to experience before the accident.

Before the case recorded on p. 92 came under my notice I had come to recognise the essential difference, and the importance of distinguishing, between Retroversion and Retroflexion, not only from an anatomical point of view, but also in respect of treatment. Yet I was anxious again to test the correctness of my views, and the value of the vaginal pessary; and I had the less hesitation in doing so, as the cervical canal was very open, and there was consequently no dysmenorrhœa. What I have so long held was here illustrated most unmistakably, for the body of the uterus was so bent over the posterior bar that I could not pass the sound while the pessary was *in situ*. With the view of keeping the cervix as high and as far back in the vagina as possible, I bent the instrument into a short S shape; but the result was the same. We are told by some gynæcologists that if the cervix be kept well back, the intra-abdominal pressure of the intestines will carry the body forwards. I venture to affirm that it will not do so in a case of well-marked flexion. In this case we have a well-marked flexion, with some version added, and we see a practical refutation of the argument. The substitution of a Meadows' compound stem, however, brought about the desired result. This was worn for twelve months uninterruptedly. Within three weeks of its removal it

was evident that the uterus was falling back again, and I re-introduced the instrument for another period of seven to eight months, when it got displaced and the patient removed it. By this accident it is probable that the uterus was forcibly displaced, for thus I found it on examination. But there was this difference, that the displacement was now a pure version, and the left ovary was also brought down. The stem was now set at an acute angle to the frame, with the view of keeping the uterus somewhat anteverted, so as to assist in the restoration of the ovary. This was completed in a short time, and at the end of five months I felt confidence in entrusting the support of the uterus to a Hodge's pessary.

Now it is of great importance to recognize the difference between Retro*version* and Retro*flexion*, and cases will be given to illustrate this importance in view of treatment. The lines of demarcation overlap one another, so that it is often difficult to say, of a particular case, whether it is essentially a *version* or a *flexion*. Thus the uterus may, in the first instance, have been simply retroverted, but in consequence of the cervix meeting with more resistance in its forward and upward movement, than the body in its downward, an amount of flexion has been superadded, whose intensity will bear a direct relation to the difference between the degrees of resistance.

How is this question to be settled? I am in the habit of regarding the position and direction of the

cervix as the chief test. For instance, if the os point towards the coccyx, and the fundus can be felt in Douglas's pouch, close behind the cervix, with the usual sulcus between the body and cervix, the case is a true Retroflexion. If, on the other hand, the cervix be found behind the pubes, with the os pointing more or less towards it, or even above it, the case is one of Retroversion. Under the last-named circumstances the uterus is almost completely inverted. There is no difficulty in distinguishing between these two conditions. But there are all shades of gradation between these two extremes, and the nearer the case approaches the intermediate position the greater is the difficulty. Let me take one of these. The uterine body is down in Douglas's pouch and the os points to the vaginal outlet, so that the finger as it passes up the vagina goes straight into the os. Such a case, notwithstanding that there is a distinct bend at the junction of the body and cervix, whose concavity looks backwards, is *essentially* a Retro*version.* If, in such a case, the cervix be pressed backwards, the body will be found to recede from the finger in a corresponding degree, until it can be made to attain its normal position. To take another instance. The body is in the same position, but the cervix is not so far forward, that is, so low in the vagina, yet distinctly in advance of its natural position, and the os points towards the anus or thereabouts; but there is a much closer approximation of the body to the cervix, and the sulcus is

deeper. Such a case is *essentially* a Retro*flexion;* and it will be found that on pressing the cervix backwards, the uterus is doubled upon itself, and the body does not rise correspondingly out of its unnatural position.

Considerable difference of opinion exists as to the relative frequency of these two conditions. Scarcely two authors agree. This difference of opinion arises, in great measure, from the difference of the views held as to what constitutes version and what flexion. A few quotations will make this clear. Dr. Graily Hewitt says, in his third edition—"Changes in the form of the uterus are described under the term 'flexion and version,' the two being often confounded. Flexion of the uterus is generally associated with some degree of version, but there may be version without flexion." In the 4th edition he expresses himself thus: "It is very generally the case that *version of the uterus is conjoined with flexion* of the organ, though in some cases the axis of the uterus is actually undisturbed, and there is version pure and simple."* While in the 3rd edition he so confounded the two conditions, that from the beginning to the end of the chapter the term Retroversion occurs only twice, and then only, as it were, by haphazard, he makes a much clearer distinction between the two in the 4th, and I quote with satisfaction the following paragraph on the Degrees of Version. He says:

* American Ed. by Harry Marion-Sims, M.D., p. 174.

"If the uterus were perfectly rigid, and if its axis of suspension (a horizontal line drawn transversely across the pelvis at the centre of the uterus), were also fixed, the descent of the fundus backwards would imply necessarily a corresponding elevation of the os uteri. The motion would be a see-saw motion; as the fundus descended the os uteri would be elevated, there would be true retroversion. But the uterus is not absolutely rigid, and when the fundus descends backwards, it usually becomes bent above the axis of suspension, and below it also. The attachments of the cervix uteri prevent the elevation of the os, so the whole canal becomes flexed. The os uteri has different degrees of elevation in different cases." *

While he thus describes the two conditions of flexion and version—the latter with great accuracy—he does not adhere to this division in his further treatment of the subject. Nor does he make any attempt to state their relative frequency.

Dr. Barnes ostensibly observes the distinction between the two forms of backward displacement, and while he describes them under different heads, and in separate chapters, he yet confounds them. In proof of what I say, I would refer to his illustration under the head of Retroversion, showing the mode of applying Hodge's pessary, for what?—for Retroversion?—No, for Retroflexion. Hence it will not surprise us that he affirms that Retroversion is not nearly so frequent as Retroflexion.

* *Op. cit.* American Ed. pp. 251–2.

Drs. West and Duncan say that "there seems reason for believing that the different varieties of flexions of the womb, as its retroflexion and anteflexion, are of more frequent occurrence than the corresponding alteration in position of the whole of the organ which is known as Retroversion or Anteversion. In this they are totally at variance with Emmet, who tells us that "Retroversion is the most common form of uterine displacement," * a statement in which I wholly concur.

While the late Sir J. Y. Simpson † treated of backward displacement under the head of Retroversion, his successor in the professorial chair adopts the term Retroflexion.

In the recent work of Messrs. Hart and Barbour my views are strongly supported. In the opening paragraph, under the head of Retroflexion, they say "for convenience' sake this condition is usually called Retroflexion to distinguish it from Retroversion . . . . . strictly speaking, the condition is Retroversion + Retroflexion." ‡ This seems to imply that, in their opinion, there is no such thing as pure Retroflexion—a statement with which I cannot agree, but which I accept in so far as it tends to confirm my experience as to its very great rarity. But for this definition I would have said they committed the same mistake as Dr. Barnes in the ac-

* Principles and Practice of Gynæcology, 2nd Ed. p. 294.

† Selected Obstetrical and Gynæcological Works, Edited by J. Watt Black, 1871, p. 683.

‡ Manual of Gynecology, p. 334.

companying figure, in which is shown the "diagnosis of retroflexion by bimanual examination."

I call the position an essential version with only slight flexion superadded.

The same may be said of Fritsch's drawing, Fig. 2. In this illustration the uterus is represented as very moderately *flexed*, but so much retroverted that the

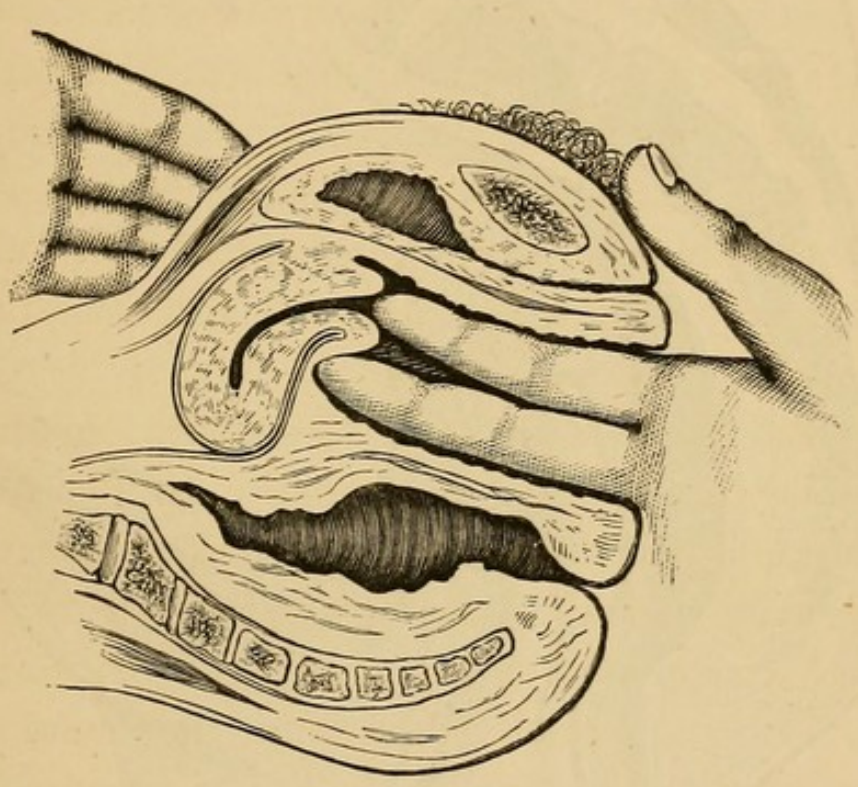


FIG. 1.—DIAGNOSIS OF RETROFLEXION BY BIMANUAL EXAMINATION (Hart and Barbour).

axis pretty nearly corresponds with the axis of the vagina.

Gaillard Thomas observes closely the distinctive character of the two forms of displacement as I have described them. He defines retroversion as consisting "in a particular *inclination* of the uterus, so that the fundus approaches the sacrum and the cervix advances towards the symphysis pubis," and

retroflexion as existing "when the body of the uterus is *bent* towards the sacrum so as to create an angle on the posterior wall. Retroversion may exist in slight degree, the uterine axis inclining so as to make with that of the superior strait an angle

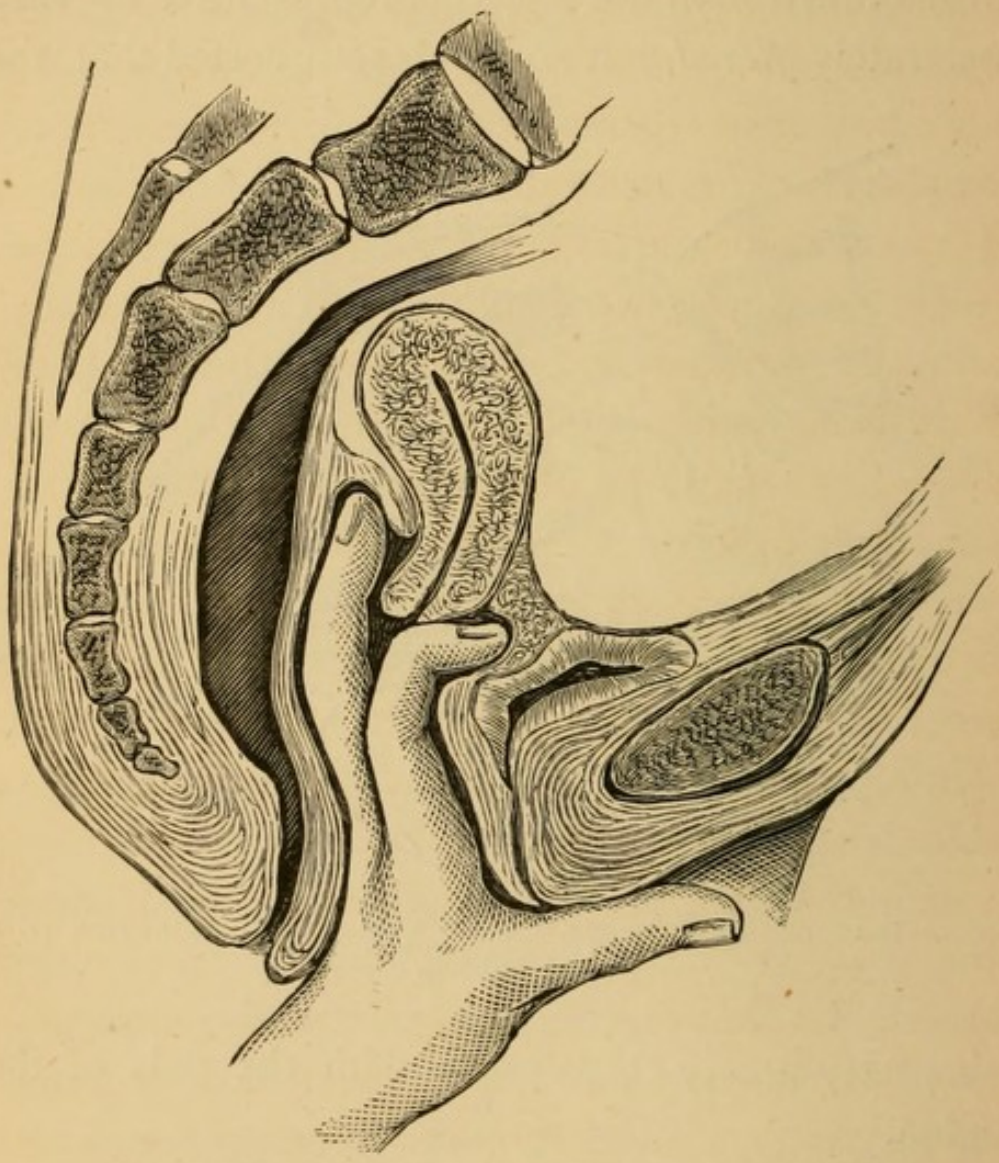


FIG. 2.—RETROVERTED AND FLECTED UTERUS (Fritsch).

of 45°, or it may incline to 90°, thus lying across the pelvis; or the cervix may be thrown up, and the fundus descend so as to form an angle of 135°. These varieties constitute the first, second and third degrees of retroversion."

"Retroflexion also has been divided into varieties dependent upon the degree of intensity, but they are so entirely arbitrary that they may as well be ignored." *

This precision of definition and description in the case of retroversion may be proper in a systematic work, but it is scarcely reducible to practice. I readily subscribe to his statement with regard to the varieties of retroflexion.

Thomas makes no attempt to state the relative frequency of these two conditions, from his own observations. Of such statistics as he has been able to collect from others, viz., Meadows, Nonat, and Scanzoni, he says "nothing but discrepancy and doubt result from the comparison of the figures of these three conscientious observers," and "after a comparison of such statistical evidence," he feels inclined to agree with Sydney Smith who says "there is nothing so unreliable as figures except facts." †

Edis is of opinion that Retroflexion is more often met with than Retroversion independently of prolapsus. ‡

Mundé, on the other hand says, "while pure anteflexion is frequently met with, retroflexion without accompanying (usually preceding) retroversion, is, in my experience, rare. I have seen many cases of retro-displacement of the uterus, and I should be false to my experience if I admitted that flexion was

* On the Diseases of Women, 5th Ed. p. 432.
† *Op. cit.* p. 432.
‡ Manual of Diseases of Women, 1st Ed. p. 92.

the most frequent variety, or the common consequence of retroversion." * This statement of view was called forth in opposition to that of Fritsch who maintains that "retroversion is almost exclusively a passing displacement," in other words that "retroversion precedes almost every retroflexion, and that retroflexion is undoubtedly the most frequent pathological position of the uterus." † Schroeder holds the same view as Fritsch.

Goodell after defining retroversion and retroflexion as I have done, in common with Thomas, says "It is rare to meet with a pure case of retroversion, that is, one without some degree of flexion, and so rare to meet with a case of retroflexion without being complicated with more or less of version that both of these displacements can be treated in pretty much the same manner." ‡

How few recognize the essential difference between a version and a flexion!

In determining the question of version or flexion the important points to bear in mind are these, viz., that in retroversion the cervix may be displaced, as Thomas says, "until the uterine axis forms with that of the superior strait an angle of even 135°" or until the os points to the top of the symphysis pubis; that a certain amount of flexion may be superadded, that the amount of flexion will depend on the varying degrees of resistance offered on the one hand to

* On the Curability of Uterine Displacements. *American Journal of Obstetrics*, Oct. 1881, p. 797.

† Fritsch. Die Lageveränderungen der Gebärmutter, p. 76.

‡ Lessons in Gynecology, 2nd Ed. pp. 134–5.

the descent of the body, and on the other hand to the ascent of the cervix, and that the more the cervix is displaced the more certainly is the case one of essential retroversion. In the case of true retroflexion the cervix is little, if at all, displaced, or inclined from the axis of the superior strait.

Guided in my observations by these distinguishing characteristics, it results from my own experience that retroversion is, in the words of Emmet, "the most common form of uterine displacement," and that the order in which they occur is this, viz., retroversion, anteflexion, anteversion, retroflexion. Thus of two thousand women who came under my notice in the out-patient department of the Samaritan Free Hospital, during the three years 1872 to 1875, of which I have tolerably accurate notes, 149 were the subject of uterine displacement, accompanied by symptoms which directed attention to the pelvic organs. That this is only an approximation I am free to admit, and for this reason among others, that many women who complained of pelvic pain or discomfort would not submit to examination. Of this number seventy-two had retroversion, fifty-one had anteflexion, twenty-one had anteversion, and only five had retroflexion. Thus there were seventy-seven cases of backward, and seventy-two of forward displacement, a statement of results, in this form, closely approaching those of Valleix and Mayer. The former gives the proportions as thirty-five deviations of the uterus forward and thirty-three backward, and the latter

sixty-five cases of the former and sixty-four of the latter.*

The mode of action of the pessary has given rise to great difference of opinion ; for while some maintain that the instrument supports the fundus directly, others affirm that the support is indirect, and that the force is exerted only through the cervix. Graily Hewitt tells us that the "Hodge's pessary pushes up the fundus and draws the cervix backwards," and Thomas seems to hold the same view. Instruments have even been constructed with the posterior transverse bar made concave on the uterine aspect, under the belief that the uterus might rest in this hollow (Gervis). Indeed, I myself at one time had mine thus formed. I maintain, on the other hand, that the support is indirect, and I have frequently demonstrated the fact that backward pressure on the cervix brings the uterine body forwards, even to a state of anteversion ; while, with a suitable position, such as the knee-shoulder position, I have, in cases of retroversion with pregnancy, repeatedly taken advantage of this fact in adjusting or re-adjusting a pessary. That the direction of the uterus can be altered by backward traction on the cervix through the vaginal wall alone, is readily demonstrated by using Neugebauer's speculum in a case of well-marked anteversion. Every one knows how difficult it is to get the os fully into view when using a Ferguson's speculum, and that it is necesssry to fix and hold

* West and Duncan, p. 189.

the uterus by means of a tenaculum or volsella. In using Neugebauer's speculum in such a case, separation of the two blades, by approximation of the handles and with the posterior blade longer than the anterior, brings the os fully into view, as thoroughly as if held by the volsella. It can also be shown that the same manœuvre will retrovert the uterus from its normal position. This results from the fact that the uterus is a more or less rigid body. Moreover, a consideration of the anatomical

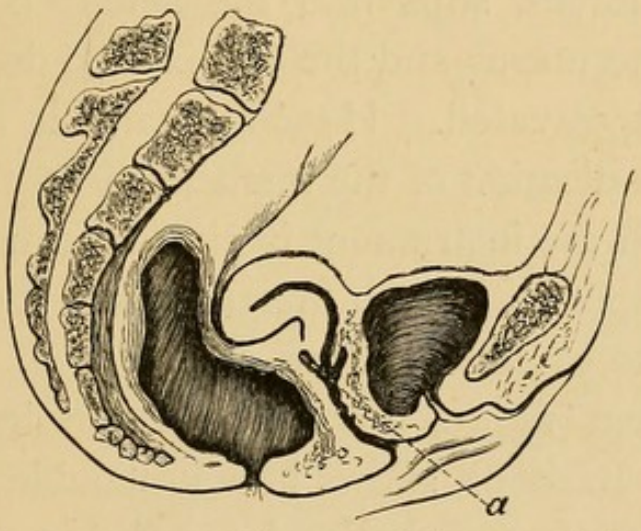


FIG. 3.—RETROFLEXION OF UTERUS. Peritoneo-vaginal septum at *a*.
(After Savage.)

relations of the parts leads us to the same conclusion. Here is a diagram illustrating the condition of retroflexion from which it will at once be seen, how impossible it is, in any ordinary circumstances, to bring pressure to bear on the fundus. Indeed I may add that it would not be desirable, even if it were possible, to construct an instrument, to do so, as it could be done only at the expense of the utero-sacral ligaments, on the integrity of which the position of the uterus so much depends. As will be

seen by the diagram a pessary acting by its transverse bar on the peritoneo-vaginal septum at *a* forces it backwards and upwards until by a great deal of stretching it, perhaps, touches the back of the body. At the same time it drags the cervix in the same direction, with the effect of still further doubling the uterus upon itself, except in so far as it is obviated by a rotatory movement of the latter. But this is not all; for experience tells us that the posterior transverse bar, taking the diagonal of the opposing forces, slips into the sulcus between the body of the uterus and the cervix, and the condition is only aggravated. Hence I take it as a most valuable indication of the inefficiency of the pessary when, with the instrument in sitû, I cannot re-introduce the sound. As an illustration of this I would refer to the cases which are reported.

The next figure, for which I am indebted to Hart and Barbour, shows how untenable is the idea of direct support of the fundus, and that the support is indirect, in the manner I have just explained. This is the view supported by Herman, when he says, "It is certain that it (the pessary) cannot by direct pressure upon the body push a retroverted or a retroflexed uterus into the axis of the pelvic inlet."* On the other hand Edis holds the view that the pessary supports the fundus directly. He says, "Instead of inserting an ordinary Hodge's pessary, which *presses unduly upon the fundus uteri*, and often causes much discomfort, an elastic ring . . . . . is

* *Medical Times and Gazette*, Nov. 17, 1883.

much more likely to be tolerated ; and by its uniform distension of the posterior cul-de-sac is less likely to press unduly upon the tender fundus uteri than the posterior limb of a Hodge's pessary."*

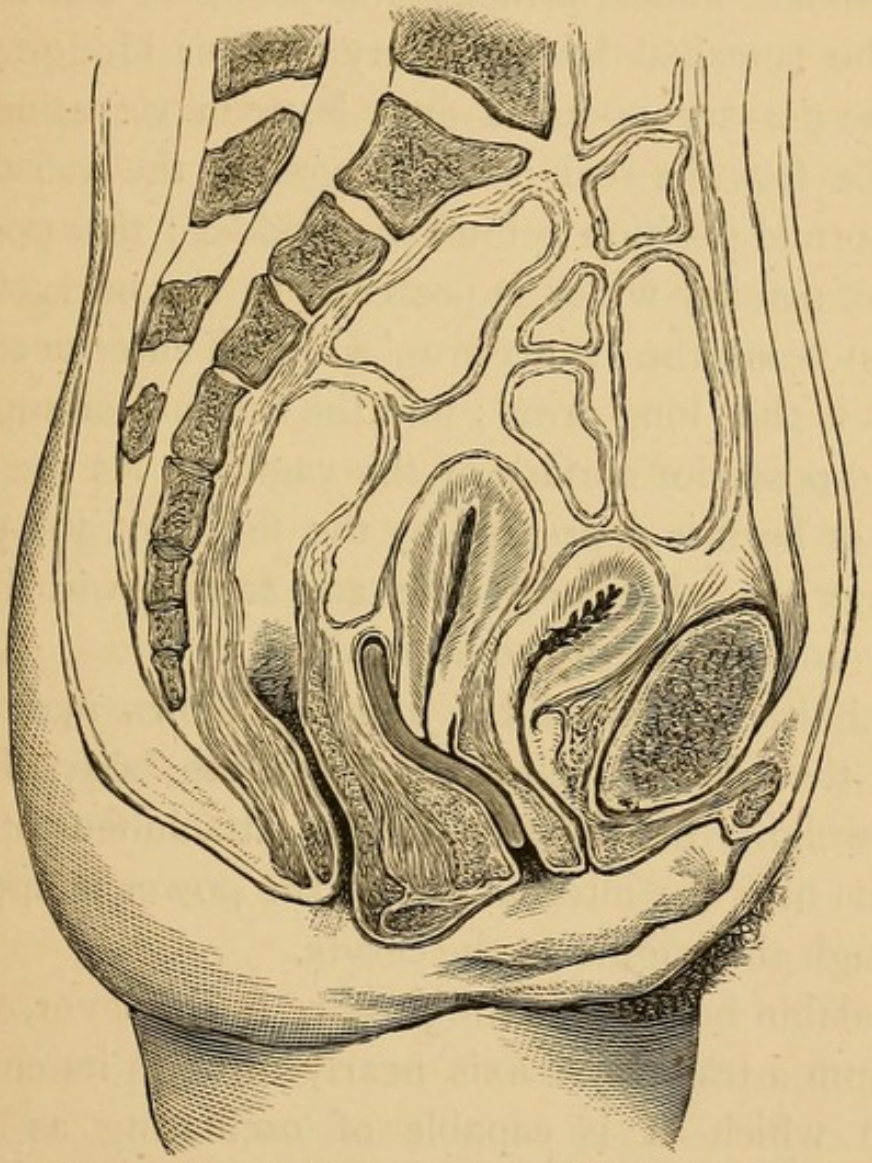


FIG. 4.—HODGE'S PESSARY *IN SITU.* (Hart and Barbour.)

Hence the uselessness, as I have so long maintained, of the vaginal pessary in a case of true retroflexion. I would even go so far as to say that it is positively injurious. On this point Fritsch

* The Treatment of Chronic Metritis associated with Retroflexion (? Retroversion). *British Medical Journal*, Sep. 22, 1883, p. 573.

admits that "a vaginal pessary has not been conceived, which can convert a retroflexion into an anteversion by its own action."*

Several views have been advanced in explanation of the mechanical principles involved in the action of the so-called lever-pessary. Thus Hodge says, "The pessary operates as a lever in elevating the fundus from its real position against the sacrum to its normal position behind the bladder; that portion of the pessary which is posterior to the neck of the organ being the 'short arm,' while all anterior to the neck is the 'long arm'; and the fulcrum or support is the posterior surface of the vagina. As the long arm or horn is depressed by the finger of the practitioner, the short arm rises and carries with it the body and fundus of the uterus."†

Schultze, followed by John Williams, maintains that the uterus itself is the lever, the body of it is the weight, the fulcrum is the attachment of the uterus near the internal os, and the power is applied through the vagina to the cervix.

Galabin holds that the pessary is the lever, "the fulcrum a transverse axis nearly through its centre, upon which it is capable of oscillating as it is grasped by the vaginal walls; the power is the pressure of the anterior vaginal wall upon its anterior limb, greatly increased during expulsive efforts; the weight, or resistance, is the fundus uteri which is pushed up by the posterior limb."‡

* *Op. cit.* p. 117.

† Diseases peculiar to Women, 2nd Ed. 1868, p. 417.

‡ Diseases of Women, 1st Ed. p. 68.

Goodell says, "this pessary acts on the principle of a lever, but the mechanism of its action is two-fold. By stretching the vagina upward and back-wa d, it draws the cervix in the same direction. The womb then turns on its central point of liga-mentous attachment, as on a fixed point, and the fundus is consequently tilted forward. The womb itself then becomes a lever, of which its point of attachment to the bladder is the fulcrum. The power is applied to the cervix, and the fundus becomes the weight or resistance . . . . Then again the pessary itself acts as a lever. The anterior vaginal wall, with the visceral pressure above it, now becomes the power applied to the lower limb, or 'long arm,' of the lever, the posterior vaginal wall is the fulcrum, or support, and the upper limb, or 'short arm,' lying behind the cervix directly pushes up the weight, or fundus uteri."*

Such, then, are some of the explanations of the mechanical principles involved, and I shall not render "confusion worse confounded" by offering another. Choose which you will.

It has been asserted that Hodge's pessary, while it may and does relieve symptoms, never *cures* a retroversion.

This subject has, of recent years, occupied the attention of several authors, amongst whom Fritsch has treated it at great length. He says, "It may happen that the uterus retains its position after its first replacement. In recent cases, therefore, the

* Lessons in Gynecology, 2nd Ed. pp. 156-7.

attempt may be made to remove the pessary after the first menstrual period . . . . and the patient be examined for several days to ascertain whether the uterus is still in its correct position. If all is right the patient should be told to return on the re-appearance of the first symptom. But if the retroflexion (*sic*) soon return, or the parametran tissues be greatly relaxed, the pessary must be worn for a long time, so long as it gives no inconvenience. . . . . It is *admitted that only in recent cases is a permanent cure to be expected.* (I, for one, do not admit this statement.) If the tissues about the uterus are relaxed the retroflexion at once returns, when the pessary which had retained the uterus in its normal position for a year or more is removed. . . . . Cases are not rare where the patient returns months or years after the removal of the pessary full of gratitude for her cure (?), and on examining with the happy anticipation of finding the retroflexion cured, behold! the displacement is discovered entirely unchanged. In such cases the symptoms may return after a while, and the pessary be again required."

Now, I am far from agreeing with Fritsch in the unfavourable view he takes of the ultimate results to be attained by the use of the pessary. Did Fritsch employ the term Retroflexion in the sense in which I use it, I would say that his want of success is not to be wondered at. He does not distinguish between an essential version and flexion. This explains much. When he says, "It may happen

that the uterus retains its position after the replacement,"* I would lay great stress on the word *may*. I have never known such a thing happen, and I cannot but express the strongest disapproval of the practice of removing the instrument at so early a period as the first menstruation. I have often heard it stated that it was the practice of the speakers to replace the uterus by means of the sound, and then leave it, adding that this was sufficient. Fond delusion! If the trouble or care had been taken to examine the patient an hour—even half-an-hour—afterwards, I venture to affirm that the uterus would have been found as much displaced as formerly. Any one who has had the opportunity of straightening the retroflexed uterus, or replacing the retroverted organ, by means of the hand within the peritoneal cavity, as in the course of ovariotomy, must have been struck with the persistence with which it returns to its unnatural position.

Yet with all his distrust of the pessary, Fritsch says, Radical cure, *i.e.*, permanent retention of the uterus in the normal position, is to be achieved in not a few instances. That these consist chiefly of recent cases, that is, such as come under treatment soon after childbirth, or the development of the displacement, is "self-evident." In what respect this is "self-evident" I fail to see.

Even more explicit in the unfavourable judgment he has formed of the pessary is Chrobak, who

* Die Lageveränderungen der Gebärmutter, p. 76.

says—"With the exception of the rare cases in which a cure of the displacement has taken place through the use of a pessary either by *gangrene from pressure* with subsequent contraction, or that the case was a recent one, as after childbirth, the instances of actual cure of uterine displacement by pessaries are of very rare occurrence. Usually we scarcely succeed in restoring the uterus to its normal position, and must be content, in the large majority of cases, with having achieved a diminution of the displacement, in flexions generally merely a decrease of the version, usually in the same direction, accompanying it." Mark the confusion of ideas in the last sentence. One can scarcely believe that the writer is in sober earnest in speaking of cure of displacement by *gangrene from pressure.* It is devoutly to be wished that such cases are rare, if indeed they do occur at all. If there is one thing that we have to guard against more than another in the use of the pessary it is the infliction of any injury on the vaginal walls, and the presence of any discomfort ought in all cases to be the signal for immediate removal of the instrument. In fact, the patient ought to be unconscious of its presence, if we hope to do any good, or to avoid injury.

Mundé is scarcely less discouraging than Fritsch in his remarks on this matter; but I feel assured he has not done himself justice.

"How many of the 184 cases of uterine displacement (tabulated by him) treated by supports of one kind or the other were *permanently* cured I am

unable to say; for, probably, the same reason that has prevented other observers from collecting positive data, viz.: because patients who find themselves benefited by a supporter go on wearing it for a while, finally remove it themselves, and finding their relief to continue without the pessary, do not return, and are thus lost sight of. That they do not return is no proof, however, that their displacement was cured." Nor is it any disproof, though the evidence, such as it is, is in favour of the view opposed to that adopted by Mundé. "I can find but two cases of positive cure, as demonstrated by occasional examination, of sharp retroflexion; five of retroversion . . . . . three of anteflexion with retroversion, treated by the intra-uterine stem and Albert Smith pessary, and one of sharp anteflexion treated by dilatation with laminaria steel dilators and hard rubber stem during six months."

He goes on to say, "I do not deny that other cases *may* have been cured, but I am unable to make a positive statement on this matter. . . . . Had all my cases been private patients, instead of a large proportion in the out-door clinic of a hospital (than which class of patients I need hardly say there is nothing more uncertain and unsatisfactory, so far as therapeutic results are concerned) I might have a better showing."*

I have had so often to experience this uncertainty in out-door hospital practice that I can sympathize with Mundé in the last sentence. Some years ago

* American Journal of Obstetrics, Oct. 1881.

I began to work out an analysis of a series of 4,000 cases in the out-patient department of the Samaritan Free Hospital, but when I came to the question of results I was completely baffled. One is not wholly free from this cause of disappointment even in private practice. Patients will not travel long distances merely to state that they are quite well, and it is a fair presumption that in a large majority of cases the patients who do not return have been cured. Of this I had a striking instance only a few months ago. I was accosted one day at a public entertainment by a lady whose face I had forgotten, and who came up to me, saying she could not refrain from making herself known in order that she might thank me for having operated on her some years ago; for that, in consequence of that she was now the happy mother of several—I forget how many—children. She had been married several years, suffered from dysmenorrhœa due to anteflexion with constriction, and I divided the cervix in my usual way.

The following quotation from Matthews Duncan will excite no surprise :—"Displacement was never cured in the sense that the uterus afterwards remained in place without a pessary." Of pessaries he says, "They are always harbourers of dirt, and they always keep the mind watching the part. They are liable to decay, and require, if long used, to be renewed. They all are undesirable additions to the contents of the pelvic excavation, and if they *are efficient* must, of course, cause more pressure than that caused by the organ or organs which they keep in altreed

position, though perhaps on altered parts." As Grandin says, in reviewing the work from which this quotation is taken, "it would be a waste of time to refute the fallacies contained in it." But I may remark that the cases already given abundantly disprove such a statement. I contend, also, that those cases, in which the use of a Hodge's pessary has been followed by pregnancy in women hitherto sterile, may be called cures, as also those in which repeated miscarriages have been prevented and the patients have gone on bearing children (Cases IV. and VI.). Should the retroversion return after another pregnancy it cannot be said that the displacement was not cured, any more than it can be said of a man who breaks his leg, or dislocates his shoulder a second time, that he was not cured the first time.

The following case may be here cited in illustration.

Case XIV. — *Retroversion with sub-involution; Hodge's pessary; subsequent pregnancy and return of the Retroversion.*

Mrs. H——, aged twenty-five, mother of two children, came under my care on January 2nd, 1880. Her second child was born on January 31st, 1878. The labour was a very good one, but circumstances compelled her to get up at the end of a fortnight, and exert herself unusually. She soon began to

complain of pain in the sacral and hypogastric regions. At the end of four months she weaned the baby, and the menses soon re-appeared. She now complains of more or less constant aching in the above-mentioned sites, and walking or standing causes her so much suffering that she is obliged to pass the greater part of the day in the recumbent position. For the last two months or more she has worn, during the day, a vaginal pessary with external straps, in the form of a china stem, cup-shaped at its upper extremity, but it has given her no relief. Menses regular and rather scanty; no pain to speak of. She suffers very much from facial neuralgia, and looks very ill. She has a troublesome cough, with a few large mucous rales, the remains of an attach of bronchitis. The appetite is bad, the tongue furred, and the bowels are constipated.

On examination I found the uterus retroverted, with the os pointing to the lower border of the symphysis pubis, and the body tender to the touch in the attempt to elevate it; there was a rather abundant catarrhal discharge, not purulent. The sound entered very easily, and to the extent of $3\frac{1}{2}$ inches, but with the concavity towards the sacrum; the fundus was tender when pressed upon by the sound: the uterus was easily replaced. While it was supported in its normal position with the sound, as the patient lay in the dorsal posture, a No. 7 Hodge's pessary was introduced, and kept the sound steady. On getting up, the patient was at

once sensible of great relief, and she voluntarily contrasted the difference between the two instruments.

I recommended the hot douche to be used daily, and for the neuralgia prescribed Ammon. Chlor. gr. 20, Ammon. Carb. gr. 2½, Chloral Hydr. gr. 5 every two or three hours.

Next day the uterus was in very good position, and the sound entered easily in the normal direction (almost by its own weight): the neuralgia had been very severe during the night, but had ceased by the time of my visit. I then prescribed Easton's Syrup, (the Ammonia mixture to be reserved for the neuralgia,) and a pill containing Extr. Coloc. Co. gr. 1; Extr. Hyoscyami gr. 1; Res. Scam. gr. ½, to be taken at bedtime as required.

On the 22nd the uterus was still well supported—it was perhaps a little anteverted: the neuralgia had not returned at all in its former severity, and had quite ceased; the appetite had improved, but the bowels were so constipated as to require the regular use of the pill; the cough also was rather troublesome. I substituted the following mixture for the pills, viz.: Fer. Sulph. gr. 2, Magnes. Sulph. gr. 60, Acid. Sulph. Dil. ♏ 5—to be taken early in the morning in half a tumblerful of warm water, and as there was some doubt as to the state of the lungs, for which the emaciated condition of the patient furnished some ground, I requested her to consult Dr. Frederick Roberts. The result of his examination was that he pronounced her free from

any serious organic disease, and approved of her intention of going to New Zealand.

For February 13th, the next visit, I find the following report :—" Menstruated last from 2nd to 8th ; flow more abundant than formerly, no pain to speak of, nor bearing down during the flow, but during the week preceding and the two days following it. She bore the journey well from Red Hill yesterday: has a little bearing down now, and it is aggravated by walking, but is slight compared with her former suffering. Uterus is in very good position, still a trifle anteverted, if anything. There is no noticeable vaginal discharge, though she has neglected the use of the douche. The saline chalybeate suits her well."

On September 13th she reported that she was very comfortable, and felt nothing of the instrument. Menses regular and in normal quantity ; no leucorrhœa ; appetite fairly good, and the aperient mixture only occasionally required. Instead of Easton's syrup I prescribed Ammon. Chlor. gr. 10, Liq. Am. Acet. fl. dr. 1, three times a day, as the uterus was still large.

I saw her again in May, 1881, just before she set sail for South Africa. She was in excellent health, and the uterus in its normal position, and I recommended her not to be in a hurry to remove the pessary.

July 25th, 1883.—The patient has returned today, looking very ill, and has made the following statement :—" I left for the Cape in May, 1881, and, after arrival at Queenstown, went between 200

and 300 miles inland, from East London. I was very well till the following April (1882), when I had a threatening of miscarriage at four-and-a-half months. I was then wearing the instrument. The symptoms passed off, and the instrument was removed six weeks after. The child was born on September 30th, and for two months I had repeated small hæmorrhages. Labour lasted only an hour, and I got up on the fourteenth day. Illness broke out in the family, I lost my white servant, and the blacks would not stay with me during the night, so I very soon got knocked up. I felt weak, and began to suffer from my old symptoms—bearing down and pain—the bowels were constipated, and I lost my appetite. At last the bearing down became so distressing that I was obliged to consult the doctor, and he applied an instrument; but it has not relieved me in any way. Finding that I was no better, but rather worse, and that my health was failing, my husband decided to send me home again to see you. I landed only yesterday. I was sick nearly all the way home, but suffered very little on the way out."

She complained of pain and bearing down on the slightest exertion: the menses were regular, very scanty: no leucorrhœa, appetite very bad, bowels regular. She looked worn and ill, and presented very much the same appearance as when I first saw her. On examination I found a small Hodge's pessary in the vagina: the sound, on reaching the internal os, had to be turned with the concavity of

the bend backwards before it would enter the cavity, so that she was in a fair way for getting a *Retroflexion* instead of a *Retroversion*; the uterus was very large, the sound entering for over three inches. I removed the instrument, which was at least an inch too short, and substituted the original instrument, which she had carefully preserved and brought with her, and which her medical attendant had refused to use. The result was that she immediately felt relieved.

She still wears the instrument, and as I have not heard from her again, I think I may fairly assume that it still answers its purpose, as she promised to let me know to the contrary. When I saw her two days afterwards she had lost the "pain in the back."

This case abundantly refutes Dr. Matthews Duncan's objections; the instrument was not a "harbourer of dirt," for she got rid of her leucorrhœa: it did not "keep the mind always on the watch," but it helped her to forget that she had anything the matter, and almost to forget that she had an instrument at all: it showed no "liability to decay," for it was quite clean: nor had it "to be renewed," for it was as good as new.

I have quoted various opinions and statements, some vague, some "damning with faint praise," and others positively unfavourable to the use of the pessary, from the qualified praise of Mundé and Fritsch, down to the sweeping denunciations of Duncan. I have now the satisfaction of quoting

views of an opposite character. Thus, Schultze says: "It is to be hoped that the profession at large will soon recognize the perfect curability of most cases of Retroversion."

Dr. F. B. Watkins, of Richmond, Va., reports 215 cases of uterine displacement in which he employed mechanical supports, and achieved the following results. He does not distinguish between flexions and versions, but divides them into Retroversions, of which there were 139, and Anteversions 76. Of the Retroversions, recovery was attained in 114 cases, partial recovery in 23, and in 12 slight or no improvement. "The vaginal supporters were all constructed on the Hodge closed-lever principle, of block-tin wire and hard rubber, *accurately fitted*. The time of treatment extended over several years, and is not definitely stated."*

"In the February (1881) number of the *Chicago Medical Journal and Examiner*, Dr. P. O'Connell, of Sioux City, Iowa, published a paper on 'The Curability of Uterine Displacements,' which, while his figures are much smaller than those of Dr. Watkins's, closely follows the tenour of that gentleman's article. Dr. O'Connell begins by expressing great surprise at a statement of Dr. Matthews Duncan" (already quoted, p. 54). "In his defence of these valuable aids in *supporting* a RE*placed uterus*, I heartily join him. . . . . He reports eight cases of complete cure, the displacement being in all 'retroflexion' (should it not have been retrover-

* Mundé, *op. cit.*

sion ?), the pessary, the Albert Smith modification of Hodge's lever pessary. 'No woman was pronounced cured until it was ascertained by actual trial that she could dispense with the instrument. This is done by removing the pessary, and permitting the patient to discharge all her duties as before. If after the lapse of a few weeks, the uterus is found in normal position, as determined by the finger and *the sound*, the pessary is not reintroduced. My observation of the patients extended over one year, the shortest, to four years, the longest period, after removal of the pessary, and in no case was the displacement reproduced.'"*

Thomas expresses no direct opinion on this question, but under the head of posterior displacement, he says, "Some of the most gratifying results of gynecology will be found to arise from a cautious, patient, and philosophical treatment of these cases." Hence I presume it may be fairly taken that he considers them capable of cure. And, on the same subject Emmet expresses himself thus: "When mechanical means are applicable in the treatment of versions, we will accomplish more marked results in the prompt relief obtained, and do more towards the *final restoration to health* than by any other means."† From this, and from the whole tenour of his remarks, we may infer that he believes in the curability of Retroversion. When, however, he adds that "Retroversion and Prolapsus are the only

* Mundé, *loc. cit.* American Journal of Obstetrics, Oct. 1881.

† Principles and Practice of Gynecology, p. 310.

forms of displacement, for the correction of which we possess any reliable, or, as a rule, safe mechanical means,"* I must dissent from him, and point to the cases already, and yet to be, recorded.

That some cases are exceedingly difficult to cure I am free to admit, as also that others are incurable by anything short of intra-abdominal treatment. These will be indicated in their proper places. To maintain that every case is to be cured, would be as far from the truth as is Duncan's assertion to the contrary.

I now come to the very pertinent question of the pessary itself. Such is the ingenuity which has been expended on this instrument, that it would require a volume to enumerate and describe all its different forms; and it is not my purpose to invoke the wrath of the reader by any such infliction. Truly their name is Legion. I cannot do better, in introducing this question, than quote the following paragraphs from Emmet, with every word of which I agree. In his chapter on pessaries he thus writes:

"This subject is one of the most important, and is the least understood.

"There is a proper time for using these instruments . . . . . and there is also a proper manner of applying them.

"Without full appreciation of both of these requirements, the damage inflicted by employing pessaries, will be far greater than any chance benefit

* Emmet, *op. cit.* p. 310.

which may be obtained from them. From some members of the profession the opposition to the use of pessaries is as denunciatory as if they were condemning a species of mal-practice. This opposition may be sincere, but it is conclusive evidence of their ignorance. I have never known a practitioner who was able to fit a pessary properly, who was not also fully satisfied with the amount of benefit derived from its use.

"The practitioner, to become an expert in fitting a pessary that it may do no harm, must have a decided mechanical talent; and, that the full benefit may be derived from the use of the instrument, he must be able to appreciate slight shades of difference which would be entirely overlooked by others. The first is a gift which cannot be acquired; the second can be gained by experience, but is of little practical value unless associated with the first. I have known physicians, who, although quite dexterous in moulding the instrument, that it should do no harm, habitually failed in obtaining benefit from it, through want of observation or appreciation of what was to be accomplished in the individual case. Frequently, physicians have written to me with the request that I would send them a pessary for some case then under treatment, without their appreciating the necessity for sending proper measurements, as they would in ordering a hat or any garment through another person. The great cause of failure and disappointment in the use of pessaries lies in the fact that the vagina is expected by many to adapt

itself to any instrument which may be introduced, when in fact it is essential that the peculiarities of each individual case should be studied. In adjusting a pessary, the physician should pay as much regard to the peculiarities of shape and size of the vagina, as the dentist does to those of the mouth when fitting a set of false teeth. I am fully aware that it will be considered an extravagant statement by many, but, nevertheless, I do not hesitate to make the assertion that scarcely two women can be found who will be benefited by wearing exactly the same shaped instrument. Fortunately, it is true, there are many women who are able to tolerate an ill-fitting instrument without receiving injury, but they are not benefited, except it be by sheer good luck.

"Several years ago, I was urged to endorse a pessary, which had some merit, but it had been patented. I refused on this ground, and as a matter of principle, since my self-respect would not allow my name to be associated with anything which was to be advertised. The inventor was so importunate, that, to get rid of him, I pointed to a lot of old pessaries, and told him, if he could find any two which were exactly of the same size and shape, I would change my mind. I had just had my office refitted, and into a small keg there had been thrown the accumulation of many years, in the shape of pessaries which had been formed from the ordinary block-tin rings. In full confidence, this man, having spread them over the floor, spent several hours looking over between five and six hundred pessaries

which had been fitted and worn by as many individuals, but was unable to find what he sought for."*

Such, then, are the views of this distinguished gynæcologist.

The parent of all the multitudinous varieties is the ring-pessary of Hodge; but its inventor soon found out its defects, and constructed the so-called closed-lever pessary. Various modifications of this instrument have been made, but the one which finds most favour, and rightly so, because constructed on scientific principles, is that which goes by the name of Albert Smith. The accompanying illustrations, Figs. 5 and 6 represent their differences at a glance.

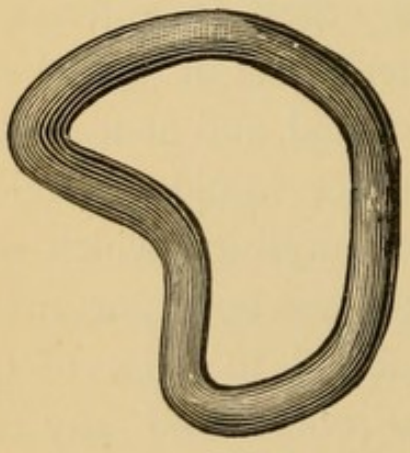


FIG. 5.—HODGE'S.

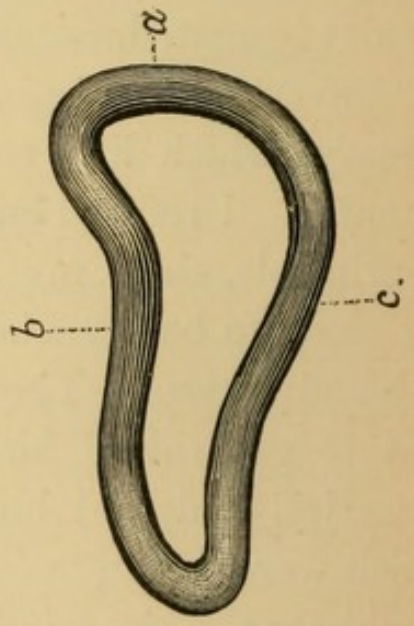


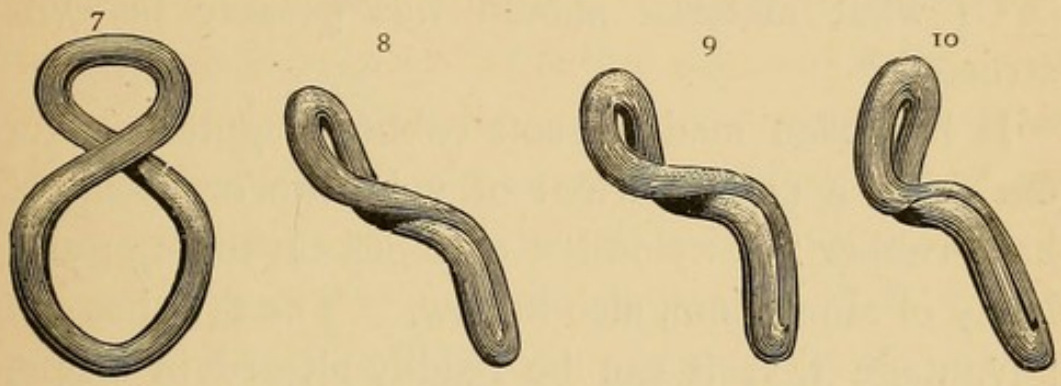
FIG. 6.—ALBERT SMITH'S.

a. Posterior transverse bar; *b*. right limb; *c*. left limb.

Albert Smith, recognizing the fact that the vagina is somewhat of a flattened pear-shape, with the apex at the outlet, narrowed the anterior extremity, and gave it a slight backward curve, with the view of

* Emmet, *op. cit.* pp. 316–17.

preventing any pressure on the urethra. In this form, when viewed sideways, it more or less resembles an elongated S. In the majority of cases this is the form that answers best, and is the one that I, in common with many others, am in the habit of using. In Germany the figure-of-8 pessary of Schultze seems to find most favour (Figs. 7 to 10).



FIGS. 7 to 10.—SCHULTZE'S PESSARY. 7. Front view; 8–10. side view of different curves.

The upper opening is intended to receive the cervix, and to assist in maintaining it in its normal position; but this has always seemed to me a disadvantage as compared with the Albert Smith, inasmuch as in the case of a large cervix a certain amount of constriction of this part can scarcely be avoided, assuming that it does retain the cervix in this way. But should it be much bent, or the cervix be very short, it must be evident that it cannot include the cervix at all, but must lie behind or below it. Still the principle of action is the same.

When the orifice of the vagina is not unduly dilated, as by rupture of the perinæum, I prefer the pure Albert Smith; but when the vulvar opening is large it is necessary to widen the instrument anteriorly, not with the view of getting points

of resistance from the rami of the pubes, but sufficiently to be grasped and retained by the soft parts. In extensive rupture of the perinæum it will sometimes be found that the instrument cannot be retained until the injury is repaired, however much it may be widened. These are the cases that call for the intelligent consideration of the gynæcologist.

Of what material should this pessary be constructed?

It has been made of soft rubber or gutta percha enclosing a copper wire: of vulcanite or so-called hard rubber: of xylonite: of block-tin tubing; and lastly of aluminium, also hollow. The first has the advantage that it can be readily altered in shape, but the great disadvantage of sooner or later irritating the vagina and setting up an offensive discharge: the second presents a clean, smooth, impermeable surface, but it is difficult to alter: the third loses its shape with the heat of the body, and if much bent becomes straightened: the fourth, which we owe to the ingenuity of the late Dr. Marion Sims combines the good qualities of the two first without any of their disadvantages: and the last possesses the great merits of extreme lightness and resistance to chemical action, but the great disadvantages of having to be fashioned from a model made from one of the others, and of being very costly.

For many years I have used the block tin pessaries only, and they are made for me in nine sizes by Messrs. Krohne and Sesemann.

I will now assume that we have to deal with a case of Essential Retroversion, that is, either a pure retroversion, or one in which a certain amount of flexion has been superadded; that the uterus is perfectly mobile and easily replaced; that there is the usual retro-cervical cul-de-sac and no vaginal constriction from cicatrization; that the mucous membrane is healthy, and that the cervix is of normal length. How are we to proceed?

In America and, I believe, in Germany also, the dorsal position is preferred. In this country the patient is often put on her left side. Of the two I infinitely prefer the dorsal position, and I do not hesitate to say that it is the only one in which not only can a thorough examination be best made, but it is also the only one in which the instrument can be applied with the greatest certainty to the operator and comfort to the patient. I had a striking instance of this quite recently in a case of long-standing retroversion. The patient had been treated for six years without any benefit, and had quite despaired of being able to obtain relief. After much persuasion on the part of her husband she consented to let me treat her. She had an inordinate dread of the sound which, she said, always gave her so much pain in the replacing of the uterus. Contrary to what she had been accustomed to, I placed her on her back, and so little pain did it give her that she could scarcely believe me when I told her that the uterus was replaced, and even raised higher than its normal position by means of the sound.

The patient, then, is placed in the dorsal position with the legs fully flexed and the feet resting on the table, obstetric chair, couch or bed, according to circumstances, and the clothing arranged so as to avoid exposure; or a shawl is thrown over the knees. It is a great gratification to a patient when she sees that the claims of decency are attended to. I, for one, would not willingly do what I have often seen done by one of our own sex, and have been told was the practice of at least some of the gentler sex who practise our art. The fore finger of the left hand, well anointed with vaseline (as the best lubricant for the purpose), is introduced into the vagina as far as the os, and the sound, set at an angle of from 100° to 120°, is passed into the uterine cavity with the concavity looking backwards. No force should be used in overcoming any obstacle, but the instrument should be gently insinuated, assisted by the information which the left index finger gives as to the direction of the canal. With a wide sweep of the handle the sound is now turned round. This manœuvre to some extent moves the os backwards but does not disturb the position of the fundus to an appreciable amount: that portion of the sound which is within the uterine cavity should simply make half a revolution. This being done, it is well to depress the cervix towards the rectum as much as possible in order to avoid the sacral promontory in the next step. If, now, the finger be placed on the posterior lip and in contact with the sound, and the instrument be

withdrawn about a quarter of an inch, the uterine body may be gently raised by depressing the handle towards the perinæum, and may even be carried above its normal height, *i.e.* until the fundus can be felt in the hypogastrium. By this means the extent of mobility can be ascertained; and if it be possible to execute this movement one may rest assured that there are no adhesions. All this time the weight of the uterus is to be borne by the left index finger. It is easy now to make a fair guess as to the size of instrument required,—especially after a little practice,—as well as the amount of curve that will be necessary. As a rule, if the sound be left it will soon be seen to incline to one side and then fall over until the uterus is retroverted as before, and the sound slips out. It is necessary, then, to provide against this either by arrangement of the clothing or by the aid of an assistant, and this should be done while one is occupied in the selection of the pessary, and perhaps in its alteration in some small, yet important, particular. It is not always necessary to grease the instrument, as the parts are already sufficiently lubricated by the passage of the anointed finger. It is even undesirable in the case of the soft rubber pessaries. (Seeing that I sincerely urge the disuse of this form, this may seem a needless instruction.) A suitable pessary having been selected, it is slipped over the handle of the sound, with the posterior transverse bar behind the sound, and while the perinæum is depressed by the left index finger and the sound

steadied against the wrist and fore arm, or, better, by an assistant, the pessary is turned on one side, the anterior or superior aspect facing the patient's left thigh, and then the lower (posterior) angle is gently insinuated into the vulvar orifice and pushed gently yet firmly within. This is the most difficult part of the manœuvre and therefore the most painful to the patient, unless the integrity of the perinæum have suffered. As soon as it is fairly within the orifice, the instrument turns into its natural position by the action of the vaginal walls, and, guided partly by the left fore finger pressing on the posterior bar, and partly by the right on the tip or anterior bar, it is pushed on well into the posterior cul-de-sac. In this way it is prevented from impinging on the posterior lip (if it be much thickened). The sound is now seized by the operator, and the uterus placed as nearly as possible in its natural position, and then let go. If it remain steady, we have a sure guide to the efficiency of the support, as we have to its inefficiency if the sound turn to one side, or perhaps half round. In the former case the sound should be withdrawn and the position of the cervix ascertained. In the latter, the pessary should be at once removed and altered as may seem necessary.

I am well aware that the sound is a very much-abused instrument, and that many evils are laid to its charge. It has even been asserted that death has resulted from its use,—and we are strongly counselled to discard it. I have no sympathy with the chorus of

condemnation with which it has been assailed. For my part I have never seen any harm result from it, and I certainly fail to see the superiority of the uterine repositor which finds so much favour across the Atlantic and German oceans. Some there are who tell us that it is not necessary to use any instrument at all; that the uterus can be replaced with the fingers; while others do not even take the trouble to replace the uterus, but at once introduce the pessary, apparently under the belief that it is going to correct the displacement and support the uterus all in one. I have seen this done by a very eminent gynæcologist, with the result which experience had taught me to anticipate. These methods fail to yield us the valuable information which the sound gives. I cannot hope to influence those who have already settled down into their own grooves, but I address myself to my younger brethren, who are perhaps only commencing practice, and have yet so much to learn, and I ask them not to be too much influenced by the advice of those experts—experts from long experience—who tell us that the replacing of the uterus by the finger is a simple and easy thing to do, and that the sound is a dangerous instrument, but rather to try them all in order to find out the best method. As to the verdict I have no manner of doubt. The sound is one of the most valuable instruments for diagnosis we possess, and it is no less valuable in treatment when properly employed. It is as the compass to the Mariner, as the steam-gauge to the Engineer.

But I insist that it should be used with care, with gentleness, with intelligence. The gynæcologist must remember that he is dealing with a delicate organism which requires no rough handling; that it is not to be whipped into obedience as though it were a responsible being; but that gentleness and firmness intelligently exercised will exact ready compliance with what it is fair to demand. Not very long ago I was consulted by a lady who was the subject of a backward displacement. She volunteered her assent to an examination provided I did not use the sound. She had been told by an eminent gynæcologist that she should never allow any one to pass the sound. I refused to undertake the case on such conditions and I saw no more of her. I have mentioned this case as the text for a protest against any man's taking upon himself to say what shall not be done by another. I trust it was a misrepresentation or misunderstanding on the part of the patient; for an instrument which may be perfectly harmless in the hands of one man may be a dangerous one in the hands of another. Through the injudicious advice—whatever its exact terms were—this patient had "Sound on the brain" added to her displacement in the pelvis.

A word or two must be said on the replacement of the uterus by means of one or two fingers. In the case of a very well-marked version this may easily be done by one finger; but where there is much flexion added it is very difficult, if not impossible. In such a case the finger occupies the space

which ought to be taken by the cervix in the vain attempt to elevate the fundus, and if pressure anteriorly on the cervix alone be employed the amount of success will depend on the rigidity of the uterus. This method is represented by Fritsch, and Hart and Barbour, as being effected by placing one finger in front of the cervix and the other behind. I repeat that it is not possible in all cases to push a retroverted, much less a retroflected uterus into its normal position by pressure through the vagina, and in this we miss one of the greatest advantages of the sound or repositor—viz., the power of drawing the uterus forwards so as to allow the small intestine to occupy Douglas's pouch—its normal occupant in the natural state of things. Ranney* has contributed an elaborate paper on the "Topographical Relations of the Female Pelvic Organs," in which he finds fault with Savage's plate, and in which he figures what he deems the normal relations of the pelvic contents, and he represents the uterus as being in contact with the rectum running straight up in front of the promontory of the sacrum. But apart from this latter error I would point out that the experience of those who have either intentionally or accidentally opened the posterior vaginal cul-de-sac tells us that the small intestine is always exposed. And my own observation in the operation of oöphorectomy without uterine enlargement confirms this, in every instance.

But, further, the introduction of two fingers into

* American Journal of Obstetrics, 1883.

the vagina of a virgin is not a painless proceeding as compared with one finger and the sound, while shortening of the cervix renders the method wholly inefficient. Sufficient leverage cannot be attained through the cervix, and we must have recourse to the sound to restore the organ to its proper position. But I am anticipating.

We have, then, succeeded in replacing the uterus and adapting the pessary. What is next to be done? I recommend that, before the patient is dismissed, the sound should be re-introduced to ascertain whether the uterus retains its position. If so, she is requested to stand up, to walk across the room, and to say what she feels. The answer is usually something like this:—"I feel as if something is gone from my back;" "I don't feel anything;" or "I feel very comfortable"—an answer indicating that she has been, so far, benefited. I have often surprised a patient by telling her that she had got an instrument in. If, however, an answer of this kind be not given, depend upon it that the instrument is not doing what is desired of it. It will then be best to replace her on her back, and to use the sound again. If it do not pass easily it will be necessary to find out in what respect the pessary fails, and it is better not to use the pessary at all than to send the patient away with an ill fitting instrument. In this I am at variance with Braxton Hicks, who regards it of no consequence that the uterus should be at once accurately replaced. Some women have a difficulty in express-

ing what they feel, but in most cases it will be possible to decide that any discomfort the patient may be feeling is due to the effect of the sound in the interior of a uterus that is the seat of so-called chronic endometritis. Satisfied on this point the patient may now be sent away and requested to return in two or three days. If, at the end of this time the sound can be readily passed she may be told to present herself after the next period, and if the condition be still satisfactory she may be dismissed for several months with instructions to use the warm douche daily, or at least frequently. It is *not necessary* that the patient should be seen every day for one week, much less for several weeks. This is an abuse of the patient's confidence, and an unwarrantable liberty with her pocket, while the frequent vaginal examinations involved are apt to do more harm than good to the position of the uterus and instrument. For the same reason marital relations should be prohibited until after the third visit, or until several weeks have elapsed, when, all circumstances being favourable, they may be resumed. Should pregnancy ensue, as it often does, the cure may be completed.

The appearance of any muco-purulent discharge which the diligent use of the warm douche does not remove, should indicate that the instrument must be seen to, and the gynæcologist will act accordingly.

Should the patient, being a married woman, become pregnant, she may be instructed to remove the pessary when she is well-advanced towards the

completion of the fourth month. Sometimes the pregnant state leads to so much relaxation of the vagina that a larger instrument will be required, as in Case IV. ; but this does not often happen.

Assuming that the pregnancy ends at full time, the patient should be kept in bed for three weeks or a month, and on no account allowed to lie on her back, or to strain, should the bowels become constipated. In several cases I have seen the displacement return, again to be relieved by a pessary, and followed by another pregnancy ; but in all such cases no special care has been observed during the puerperium.

Then, she should be told to avoid straining, as at stool, or in lifting a weight (Case VI.), and constipation should be met by appropriate diet or medicinal treatment.

But, let us now assume that at the next visit the sound does not pass readily : perhaps it may be impossible to introduce it at all. The instrument must be removed, and the condition of the uterus examined. If there be some degree of flexion, and it appears that this is the cause of the difficulty, the instrument should be shortened by bending into a shorter S-shape so as to carry the cervix as high as possible in the pelvis, *i.e.*, into the position of anteversion. Or, perhaps the first instrument may have been too small ; then the next size is substituted, of such form as reflexion may suggest. Should this fail, then it is evident that the combined uterine and vaginal instrument must be resorted to.

Sometimes the cervix is so shortened, almost to obliteration, that instead of the pessary's remaining behind in the posterior cul-de-sac, it slips forwards and impinges directly on the os. Then, also, the combined instrument will be required.

Again, there is an essential version, but the attempt to replace the uterus indicates that great resistance is offered, and as soon as the sound or repositor is withdrawn the uterus at once resumes its faulty position. We have now probably to deal with adhesions. I have seen it somewhere stated that these adhesions may be broken down by bimanual manipulation. I am far from accepting such a statement. Indeed, I believe it to be impossible. Any one who has had to break down uterine adhesions, with all the advantages which abdominal section gives him, will readily agree with me. These adhesions sometimes cover a large surface, and are continuous, and it is a difficult operation, requiring great tact and delicacy, besides being usually attended with considerable bleeding. Sometimes, however, they are filamentous, or in the form of bands. Yet these offer very great resistance, and I believe are incapable of rupture by any force that we can apply by the bimanual method. In such a case nothing can be done except by abdominal section. In illustration of this the following case may be given.

Case XV.—*Retroversion of uterus with flexion; severe dysmenorrhœa; menorrhagia intercurrent; adhesions of uterus; removal of ovaries and tubes by abdominal section; division of adhesions. Cure.*

Mrs. B——, aged 30, married five years, no issue, gave the following history. On February 1st, 1879, the period having been delayed a few days, the flow appeared in the form of a slight show which lasted two days, and then became very excessive, with paroxysmal pains. This excess continued for several days. (Patient thinks this was a miscarriage.) Fourteen days later she was thrown out of a waggon while travelling in a wild part of the Continent, and was "much shaken." From this time she suffered from great pain in the left groin. The periods returned with regularity, the flow was excessive, and the pain very severe. So great was the loss that she became decidedly anæmic. In the intervals there was a considerable leucorrhœal discharge, very yellow. In July, 1880, she again passed her time by a few days, had a fright, and again had a severe loss, with great pain in the back and left groin, paroxysmal, and she was much reduced. In course of time, however, the periods became regular, but the flow was excessive and painful, and there was leucorrhœa in the intervals. On April 3rd, 1882, after cauterisation of the uterus she had severe flooding for four days, and a mode-

rate flow for several more. The periods again became regular, lasting for five days, excessive in quantity, flow very dark in colour with numerous coagula, and accompanied by very severe pain. The period immediately preceding my first acquaintance with the patient lasted from the 5th to 9th July: the pain was very severe the first day, and then passed into a "soreness," with occasional sharp shooting pains in the left groin and hip, with numbness extending down to the knee.

The patient came under my observation, in consultation with the late Dr. Marion Sims, on July 11th, 1883. On examination we found the uterus retroverted with considerable flexion added; replacement was effected with difficulty and pain, and immediately on the withdrawal of the repositor the uterus returned to its abnormal position. She complained of great pain and tenderness in the region of the left ovary, but nothing could be detected. There was abundant leucorrhœa. The patient was well nourished, and but for an expression of suffering, would have been pronounced in good health. She complained of more or less constant pain. We then learned that she had undergone a great deal of uterine medication, that several pessaries had been tried, but all gave her so much pain that they had to be removed after a few days, and that sexual relations had become so painful to her that she had resolved not to return to her husband—the pain was intolerable. We had no hesitation in coming to the conclusion that the

uterus was retained in its faulty position by adhesions, that there was probably disease of the ovaries or tubes, or both, and we recommended abdominal section. The patient was only too ready to accept our suggestion; her husband had already hinted at the necessity for such an operation, and his consent and approval having been obtained, I operated on August 13th (1883), Dr. Marion Sims assisting. On lifting up the uterus, a strong band of adhesion, about two inches long when stretched, was brought into view, attached, on the one hand to the fundus uteri, and on the other to the bottom of Douglas's pouch towards the right, and which, immediately the uterus was let go, drew it back again. Two pairs of forceps were applied, the band was divided between, and the ends were subsequently ligatured. By means of the forceps on the extreme end, the uterus was kept up to facilitate the search for the left ovary, which for a very long time baffled our pursuit, but which was at last found atrophied and bound down by adhesions, along with its tube, to the Sigmoid flexure. It was at once removed, with as much as possible of the tube, after the application of the Staffordshire knot. The right ovary was easily found, and being in a state of cystic degeneration, resembling an aborted bunch of grapes, was also removed with its tube. Both tubes were hard and cord-like, and the lumen was almost obliterated. The result of the double ligature was, that the uterus was firmly supported in its new and normal position. In addition to the adhesion band above described,

there were several more low down in the left side of Douglas's pouch, between the uterus and rectum ; but as these could not in any way materially affect the position of the uterus, except by preventing the descent of the cervix, they were not interfered with beyond giving the highest one a prolonged squeeze with powerful forceps, in the hope of destroying its vitality, and so leading to its atrophy and disappearance. The patient made an uninterrupted recovery of the most favourable kind, although the operation lasted nearly two hours, through the difficulty met with in finding and separating the left ovary and tube. She is now quite well.

Strange to say, menstruation returned in the following January, and has continued more or less regularly ever since.

Here it may be remarked, that but for the existence of the adhesions between the back of the uterus and rectum, the displacement would probably have been a Retroversion pure and simple. These bands prevented the descent of the cervix beyond a certain extent, while the weight of intestines and the intra-abdominal pressure, depressed the fundus into Douglas's pouch into a state of flexion, which was only prevented by the rigidity of the organ from assuming an extreme degree.

It may be asked, "Do you propose this treatment for all cases in which the uterus is kept in an abnormal position by adhesions?" By no means. But, given a similar condition I should not hesitate to adopt the same measures. Without this operation

the patient was doomed to a life of misery and separation from her husband. Instead of that, her health has been completely re-established, she has been restored to her husband, and it cannot be said that she has been rendered barren by the operation.

But, if the condition of the patient be such as not to warrant such a serious operation as abdominal section, and yet we are certain of the existence of adhesions, what then is to be done? I believe that in some cases where the uterus can be replaced, and elevated into its normal position, in spite of the resistance which the adhesions offer, much, if not permanent benefit can be obtained by the compound instrument. We know that if these adhesions can be kept on the stretch for a long time—many months—their nutrition may be interfered with, so that they may ultimately atrophy and give way. We know that this does occur in the case of the pedunculated fibroid, and more rarely in that of ovarian tumour. For an instance of the former see Turner,* who reports the finding of a small calcareous fibroid free in the bottom of Douglas's pouch; a second was attached to the posterior wall of the bladder and to the pelvis, and a third was bound down to the bladder and pelvic wall by adhesions, though still retaining its connection with the uterus by a thin pedicle. I have myself removed a small calcareous body, as large as a hazel nut, from the peritoneum in the operation of ovariotomy; but its origin could not be determined.

* Prof. Turner, Ed. Medical Journal, 1861, p. 698.

The Ring Pessary—what shall I say of it? It might have sufficed to point to Hodge's own failures with it, and his introduction of the so-called lever pessary, as sufficient condemnation; but as it is evident that the instrument still finds favour in some quarters, it becomes necessary that I should not dismiss it curtly. It, or its congener, Meig's elastic ring pessary, is still represented in some of our text books, and Dr. Herman has recently spoken strongly in its defence.* For my part I never could understand what beneficial action it could exert, which was not far more effectually done by the lever pessary. Perhaps the facility with which it can be applied may account for the favour with which it is still received. It cannot keep up the posterior vaginal cul-de-sac, until by lateral pressure it is converted into an ovoid shape; and this means sooner or later ulceration of the lateral angles of the vagina. Even its advocates recognize this defect, and recommend that greater care should be taken in instructing the patient to use the douche diligently. Some years ago, an elderly woman came under my notice in the out-patient department of the Samaritan Free Hospital. She had come from a midland county, complaining of "great soreness in the private parts," and a very copious discharge, and it did not require that I should be told by her that it was offensive, even before examination. I found as the cause of the soreness a fearful muco-purulent discharge proceeding from the vagina,

* Medical Times and Gazette, Nov. 24, 1883.

and on introducing my finger, I discovered a large inflated ring, with small central aperture, which I had great difficulty in removing. The poor woman professed complete ignorance of its presence in her vagina. This instrument is unscientific in its construction and inefficient in its action. It interferes, moreover, with sexual relations, and in this respect presents a marked contrast to the lever pessary. Even patients themselves have remarked on the disadvantages, after experience of the two kinds, complaining especially of the unpleasant discharge that attends its use for even a short time. In fact it is scarcely possible to wash out the vagina with one of the instruments filling it up. But if the ring pessary of Hodge, or the elastic ring of Meigs be objectionable, much more so is that barbarous invention the inflated pessary, to which Fritsch gives the preference, and which distorts the vagina out of all semblance to its normal shape and form. Fritsch admits that, "It is true that Hodge's pessary fulfils this object better, by lengthening the vagina, and thus carrying the portio vaginalis backwards and upwards, but the vagina is still so stretched that the uterus alone through the stretching, retains its retroverted position, only lying higher as a whole. Then arise symptoms of pressure, the pessary is not well borne, but causes discharge and pain." * As Mundé says, "what else does the ring pessary do?" I may add in the words of the same author, "Why a properly-curved Hodge or Albert Smith,

* Die Lageveränderungen der Gebärmutter, p. 85.

of not too large a size, should not answer better than these clumsy, filth-retaining, and filth-breeding rings with small apertures, is not clear to me."

I possess a stock of ring pessaries which I have removed from patients (in all stages of decay), who had derived no benefit from them, who in some cases were positively injured by them, and who were at once relieved or cured by the substitution of the Albert Smith instrument. Of such the following case may be given as an example.

Case XVI.—*Retroversion; Ring pessary for nine months; failure; Hodge's pessary followed by pregnancy, &c.*

Mrs. S——, aged thirty-two, mother of two children, consulted me on August 18th, 1882, complaining of not having felt well since her last confinement, two years and a half previously, and especially of "bearing-down." For nine months had been wearing an instrument which had only to a slight degree relieved the severity of the bearing-down. Menstruation regular; flow lasting from five to seven days, moderate in quantity; severe pain the first day, extending down the right leg.

Appetite bad, tongue furred, bowels constipated. On examination I found in the vagina a large ring pessary $3\frac{1}{2}$ inches in diameter, and on removing this instrument the uterus was very much retroverted. As there was some muco-purulent discharge, I ordered vaginal injections, and requested the patient to return in three days.

August 21*st.*—The discharge having almost ceased and the uterus being still retroverted, I adapted a No. 8 Hodge's pessary, which kept the uterus in very good position, and ordered the continuance of the hot douche.

September 6th.—Uterus in good position, sound entering readily in normal direction. The bowels being still constipated I ordered a teaspoonful of Glycerine to be taken three times a day, and, as she was now quite comfortable, I sent her home.

October 6th.—Received a letter stating that she thought she had become pregnant.

October 2nd, 1883.—Was delivered of a male child three-and-a-half months ago after a very easy labour. Now complaining of pain in the hypogastrium. States that, as her old symptoms had returned soon after getting about, a ring pessary was applied; but this failing to relieve her, the Hodge's pessary was substituted after three or four weeks, but it gave her so much pain that it had to be removed. Then she resumed the ring which she wore till the day before her visit. On examination the uterus was found retroverted with a slight amount of flexion, but was easily replaced. I introduced the original lever pessary after slightly shortening, and she felt quite comfortable.

On this question I quote the following from Goodell:—"An elastic ring is more liable to do harm than any other kind. Within the last four years I have been twice called upon to remove a

Meigs' ring, which had become imbedded in the soft part. One ring, after being left in for two years, had sunk into a bed of granulations, which, overarching, had united to one another, and imprisoned the pessary for one half of its circumference. It was removed by a bloody dissection. The other having been untouched for five years, the mucous membrane had grown over about one third of its circumference. A physician had attempted its removal, but the hæmorrhage proving alarming, he sent for me. By cutting its free segment through with a pair of line forceps, I readily removed it, but the bleeding was free enough to need a tampon. Such dangerous ulceration I have never seen caused by the closed lever pessary."* Nor have I.

Patients of mine have worn the block-tin Albert Smith for over two years without producing the slightest irritation, and it is rare for me to remove it under a year.

Various devices have been resorted to as substitutes for the pessary, such as the cotton, or marine tow tampon, the sponge, and the postural treatment of Campbell. Of the first, Mundé says, "I cannot say that I have cured any ante- or retro-displacements by this treatment, although I do not doubt the possibility of this occurrence if the applications (particularly with astringents) be continued long enough and be directed to the elevating the fundus uteri."† Thomas lends his support to this method

* *Op. cit.* p. 168.

† The Curability of Uterine Displacements. American Journal of Obstetrics, Oct. 1881.

of treatment, but only as a preparatory measure. That the use of the glycerine tampon may be of service in cases of extreme congestion with hypertrophy I readily admit, but that it should be looked upon for a cure is, I think, a mistake. But what of the sponge tampon which Thomas recommends? Let Emmet answer. "Under no circumstances should a piece of sponge be introduced into the vagina as a substitute for a pessary. Of all substances which are employed for the purpose this becomes the most offensive. But the most serious objection to its use is its dilating quality, which may cause it in time to expand the vagina to the full size of the pelvic excavation; and it ceases to give the needed support unless the size is increased from time to time; moreover, its continued use destroys all the natural support and elasticity of the tissues, so much so, that, when full dilatation of the canal has taken place no effective instrumental appliances can any longer be made; and should it be necessary to resort to surgical procedure to relieve the procidentia—a condition of frequent occurrence—it will be difficult to obtain satisfactory union. I have frequently learned, on enquiry, that the use of the sponge has been recommended by physicians 'who have no faith in pessaries,' and, I may add, by those who are unable to fit them."* All these objections are heightened tenfold when patients are instructed to use it themselves.

I now come to the subject of essential Retro-

* Principles and Practice of Gynecology, pp. 326–7.

FLEXION. Though the term Retroflexion occurs in our text books much more frequently than Retroversion, with a want of precision which appears to me simply astounding, I am convinced that this displacement is an exceedingly rare one. Whilst I am well aware that amongst writers on uterine displacements I stand almost alone in this opinion, yet I know that, amongst the younger race of gynæcologists, there are some who agree with me, and I believe the day is not far distant when these views will prevail, and we shall not find the terms Retroflexion and Retroversion used indiscriminately and interchangeably. I am equally convinced that until this is attained the treatment of backward displacements will be unsatisfactory, in cases which are perfectly remediable, and for the reason that the essential nature of the displacement is not recognised.

While I maintain that the vaginal pessary used as I have described it, is the appropriate treatment for an ordinary Retroversion,—that it alone will suffice; I am equally convinced that no vaginal pessary will correct a Retroflexion. Even Fritsch says, "A (vaginal) pessary has not been conceived which can convert a retroflexion into an anteversion by its own action."*

Writers speak of "elevating" or "supporting" the fundus by this means as if the action were a direct one; but while I need not repeat what I have already said on this subject, I feel that it

* *Op. cit.* p. 117.

cannot be too persistently repeated that this is a physical impossibility. Hence then we are driven to some other device, and I know of no instrument which answers our purpose so well as Meadows' compound stem, which is illustrated in Fig. 11.

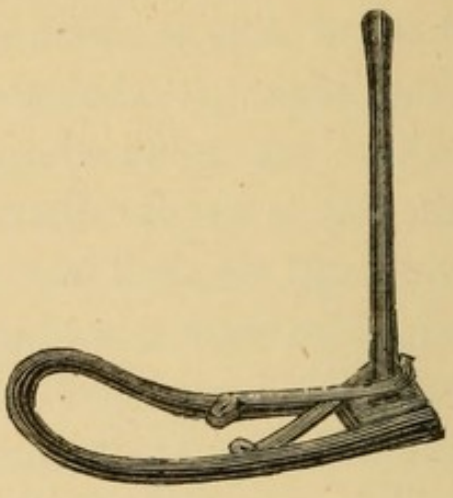


FIG. 11.—MEADOWS' COMPOUND STEM.

Case XVII.—*Retro*FLEXION ; *Vaginitis ; Hodge's pessary after the cure of the Vaginitis ; failure; Meadows' compound stem. Cure : subsequent marriage and pregnancy.*

Miss S——, aged eighteen, consulted me on July 16th, 1878, complaining of backache and vaginal discharge. Menstruation began at thirteen, and recurred with great regularity, lasting usually five days, in normal quantity and *without pain.* The appetite was good as a rule, and the bowels acted regularly : the urine often deposited urates. About two and a half years ago, she first began to have yellowish-white discharge, which was usually most abundant just after the period. From the age of twelve she

"suffered from" her "spine," complaining of back-ache, and was made to lie on her back daily for several hours. Contrary to her usual habit she had a great deal of pain at the last period, for four days, chiefly before the appearance of the flow. On examination, the vagina was found extremely congested throughout its whole extent, and bathed with a creamy discharge: there was no excoriation of the os, the uterus was sharply retroflexed, with some version, so that the os pointed in the axis of the vagina: the cervical canal was very patulous, and the sound entered the cavity with the greatest facility and without pain. On pressing the cervix backwards the fundus at once receded, but returned on removal of the pressure. I swabbed the whole vagina with a strong solution of carbolic acid, and ordered the hot douche, followed by the injection of a pint of solution of sulphurous acid (1 in 20).

30*th*.—Menstruated a few days ago with much less pain than last time. Discharge not so abundant, and more milky looking. No vaginal redness. I introduced a Hodge's pessary (which, however, was not quite to my satisfaction) and prescribed a saline chalybeate aperient.

August 2nd.—On her return home felt the instrument "low down," and has been uncomfortable ever since. On examination I found that the uterine body had fallen over the posterior transverse bar of the pessary; that, while the cervix was in its normal position, the pessary had thus slipped into the angle of flexion, so that I could not pass the sound until

I had removed the pessary. I re-introduced the pessary after converting it into a shorter S shape, with the view of tilting up the cervix abnormally, in the hope that the intra-abdominal pressure might carry the body forwards, and it seemed to act better.

September 17th.—"Reports that she soon became uncomfortable again, and at the end of a week she was obliged to remove the instrument. She had also an increase of discharge. After the removal of the pessary the discharge rapidly diminished, so that now there is very little. The uterus is displaced as at first. I substituted a Meadows' compound stem, which gave her complete relief."

There was a coloured discharge on the third day after the introduction of the stem, and it continued for five days but without pain. She menstruated at her proper time in October for ten days, flow very free, with some clots, but "*no pain* to speak of;" and so far she was unconscious of the presence of the instrument.

In *May*, 1879, she reported herself as very comfortable; there was no vaginal discharge, and the uterus was in very good position: the last period continued for six days, and was without pain.

September 25th.—"Removed the instrument; patient feeling quite well."

October 14th.—"Uterus gradually falling back; instrument replaced."

June 28th, 1880.—"Instrument came out about a fortnight ago. Uterus now *retro*VERTED, body

straight, left ovary prolapsed and tender. Altered the pessary, setting the stem at a more acute angle to the frame, and re-introduced it, keeping the uterus distinctly anteverted."

In November she returned, and as the uterine body was now well anteverted, and the ovary could no longer be felt prolapsed, I removed the stem and substituted a Hodge's pessary.

February 23rd, 1881.—Uterus in very good position : sound enters readily in the normal direction ; no leucorrhœa : menses regular and painless : ovary no longer prolapsed, nor tender. In June I removed the pessary, on ascertaining that the sound entered the uterus with the greatest facility and in the normal direction, and I readily gave my consent to her marriage in the following month.

August 18th, 1882.—The patient was married on July 16th of last year, and I now learn that she gave birth to a healthy girl at full time on the 28th ult., and is now doing well.

Meadows's instrument possesses these advantages amongst others yet to be noticed, that it keeps the uterine body straight, while it maintains the cervix in its normal position, and, if desired, even in the position of anteversion, and, that too, without too much rigidity. But it must be used with caution and intelligence.

In this instrument the vaginal frame must be proportioned to the size of the canal, in which it should lie without producing pressure. This allows

the possibility of any lateral movement that may be required, and especially that up-and-down motion which occurs in the process of respiration. In no ordinary case should the stem exceed two inches and a quarter. In the majority of cases it should not exceed two inches.

It has been objected to the stem that it produces uterine hypertrophy, and causes menorrhagia. These two objections are imaginary for the most part. What has given rise to the former I know not, but it may be assumed that the latter is due to a knowledge of the fact that the stem—particularly in the form of the galvanic stem—has been known to remove the condition of amenorrhœa, at least temporarily, and is employed for that purpose.

Case XVIII.—*Retroflexion with hypertrophy; severe menorrhagia; Hodge's pessary; failure; Meadows' compound stem. Apparent Cure.*

In the year 1879, I encountered a case of essential Retroflexion with hypertrophy and severe menorrhagia, in the person of Mrs. N——. The patient had been treated with Thomas's modification of Albert Smith's pessary, and the uterus was frequently lifted into position by the sound, and retained there for twenty or thirty minutes at a time. At that time my views were not so well defined as they have since become, and I regarded the case essentially as a Retroversion. Moreover, the very excessive menstruation, together with enlarge-

ment of the uterus—the cavity measuring over three inches—seemed to me to forbid the use of the stem. She had a more or less constant brownish, or hæmorrhagic, discharge. I applied a No. 8 Hodge's pessary, which seemed, to the touch, to support the uterus well. Two days later, however, on attempting to introduce the sound, I failed completely while the instrument was *in situ*. On removing the Hodge I found the body in Douglas's pouch. I saw then that the position of the cervix in the vagina was a delusive sign, and I determined at all hazards to try the compound stem. I therefore introduced one, and next day my anxiety was relieved by the statement of the patient, that though she had had some pain for several hours after the introduction of the stem, somewhat resembling what she used to feel after the use of the sound, yet she was then comfortable, was scarcely conscious of its presence, and there had been scarcely enough discharge to soil one napkin. I kept her in bed for two days, and in a few days more she went to the seaside, where she remained for three weeks. On the day before her return, the instrument appeared at the vaginal orifice during the effort of straining at stool, but she was able to push it back again. Fearing there was something amiss, I removed it, and on finding it in good condition, I at once replaced it. The period came on four days afterwards, and continued for seven, the flow being very free. During this time she was kept in bed. As the patient was about to

go to a distant part of the country, and fearing the instrument might again get displaced, I substituted one with a larger frame, as the vagina was rather capacious. Three months afterwards she wrote thus :—" I have been steadily improving, and now I feel so much stronger that I scarcely can believe I am myself. I have been away in S—— at my sister's wedding, and gone through such a lot of excitement as would have quite upset me some-time ago, and it has really done me good." In that month the period was more favourable than it had been for *four* years : there was no pain, and *no excess.* A month later she returned to town, and reported that she was much stronger, had no faint-ings (as previous to the commencement of the treatment) ; she could walk with comfort, and was unconscious of the presence of the instrument. The uterus and instrument were in good position, as determined by examination. In three months more she was looking remarkably well. The last period had continued for six days ; she had passed no clots, and had very little pain at the time. I removed the stem, and the uterus felt firmer. After two days, the uterus seemed to have a tendency to become retroverted, and I adapted a No. 8 Hodge's pessary, and five days later, and just before her return to the country, the sound entered readily in the normal direction. After another interval of three months, the sound did not enter so readily as I could have wished, and I shortened the instru-ment by doubling it up into a shorter S-shape.

At that time the cavity measured only 2½ inches. Her last visit was made two months later, when she reported that the last period had continued for about a week; that there were a few small clots, but that she did not require more than eight or nine napkins. The uterus was firm, os contracted to its normal size, cervix natural, and the sound entered with the greatest readiness, and caused only trifling pain. The general appearance of the patient was altogether most satisfactory, in marked contrast to her pale, sickly, emaciated appearance when I first saw her; for she had been losing flesh rapidly, according to her husband's statement. She returned home, across the Atlantic, a fortnight afterwards, and I regretted that circumstances compelled her removal from my observation, as it would have been of great interest to watch the further progress of the case. Still the facts remain, that the stem did not increase the menstrual flow—on the contrary, it diminished under its use—and that it did not cause hypertrophy, but, rather, was attended with steady diminution and ultimate disappearance of marked enlargement of the uterus. To the confirmation of these statements, the following case, though at present incomplete, also tends.

Case XIX.—*Retroflexion with some version, the result of a fall on the face; dysmenorrhœa; failure of Hodge's pessary; compound stem; relief.*

Miss B——, aged twenty, consulted me on

October 3rd, 1883, saying that during the last four months she had been passing small bodies from the vagina, which her medical attendant told her were "uterine polypi." She complained of more or less constant backache. The periods were regular, occurring every month, and usually lasting for three days; sometimes the flow was scanty, at others more abundant and natural in quantity; pain was severe, occurring sometimes at the beginning of the flow, sometimes at the end. During the last four months had passed "eight lumps," which for the most part have escaped at some period of the flow, but one passed as late as mid-interval. She felt ill generally, and was unable to pursue her musical studies.

On examination I found the os small, cervix virginal, uterus retroflected, but with so much version that I could not at once determine the class to which it belonged; the uterine body not enlarged. There was therefore no evidence of "polypus." After replacing the uterus, which was done easily, and letting go the sound, it at once turned round and slipped out. I resolved to try a vaginal pessary, and accordingly introduced a No. 2, and requested her to bring the next polypus she should pass.

November 7th.—Has been "twice unwell" since last visit, with pain at the commencement; the first on October 7th, and on the 10th she passed a small substance—the flow had by that time diminished very much; again on the 4th instant, and this

morning she passed another "polypus" with less pain than usual, though the flow was rather more free. Examination of this body shows that it is nothing but a small blood clot, as large as an almond kernel. She says it is much smaller than the former ones. She is still menstruating.

On November 13th she stated that the flow had ceased the day after her last visit. On examination I found that the sound would not pass beyond the internal os, and that the body of the uterus was flexed over the posterior transverse bar. I accordingly removed the pessary, and, recognizing the essential nature of the case, substituted a compound stem.

On November 21st, she reported that she had had a slightly coloured discharge, small in amount, till the 18th; that she was quite free from pain when lying down, but that on standing she had a little bearing-down; that for the last three days she was able to get about without any pain, but thought she could feel the instrument pressing forwards. I then learned that about a year ago she had fallen on her face, tripping over a step on the pavement, and that she was "much shaken," so much so that for several minutes she could scarcely stand, or even speak, and, having got home with difficulty, had been obliged to lie up for a considerable time. As far as she could remember, it was not until the second or third period after this that she first suffered from dysmenorrhœa, and began to pass these "polypi."

January 8th, 1884.—Menstruation quite regular,

scarcely any pain, quantity slightly more than formerly, still natural in amount; periods pass more quickly; no more clots. Instrument in very good position; causes her no inconvenience whatever, and she is not even aware of its presence. She says that since her last visit, and until she had caught a cold at Christmas time, she had felt better than she could remember. Is very anxious to resume her studies, for which she feels quite capable.

Here, then, we have further evidence that the stem pessary does not cause menorrhagia, nor set up irritation necessarily. In such a condition as this patient was in, I might well have hesitated to introduce a stem, but experience had already taught me what to do, and immediately on finding that I had to deal with an essential flexion, I acted without delay.

If it be *desirable* to see the patient soon after the application of a vaginal pessary, it is a matter of necessity that she should be carefully watched after the introduction of a stem. She should be instructed to maintain the recumbent position for some days, and not to walk about until she can do so without discomfort. And if it be necessary to observe cleanliness in the former case, it is doubly so in the latter case, as the construction of the instrument is such that discharge is more apt to accumulate about it. Hence the hot douche should be very diligently employed.

The treatment of the subject of backward dis-

placements, would have no pretensions to completeness without some notice of the postural treatment of Campbell—the so-called "uterine gymnastics." This method, practised more than twenty years ago by Von Ritgen, of Giessen, has been systematised and brought prominently before the profession by Campbell. It consists in placing the patient in the knee-chest position, and then admitting air into the vagina, either by dilating it with the finger, or, as Campbell recommends, by introducing into it a small glass tube. This, which is called by Thomas the "automatic method of replacement," is recommended to be used "for four or five minutes on retiring at night and upon rising in the morning," and is intended as the sole treatment or as an adjuvant to the pessary. Simpson and Berry Hart have given particular attention to this question, conducting experiments both in the cadaver and the living subject, and as their conclusions thoroughly confirm my own independent clinical observations, I cannot do better than quote their results. From a perusal of the literature of this subject, these authors were convinced "that all the clinical facts could not have been observed, and that consequently explanations advanced were in some points erroneous." "If," they say, "with the patient lying on her back, the uterus had its usual position, after she is put in the genu-pectoral posture, and her vagina is dilated, the uterus will be found to have passed further from the vaginal orifice, nearer to the sacrum, and become more anteverted. If it has been retroverted the displacement will be

found to have been exaggerated, *i.e.*, the anterior fornix has become shallower. For the whole uterus so moves as to approach nearer the sacrum ; and as the cervix moves over a great space, the uterus thus appears more retroverted. Replacement of the uterus may happen, if at any period of the transit the enlarged fundus is so placed that the vertical, from its centre of gravity, falls in front of the transverse axis of rotation, at the base of the broad ligaments. As a general rule, however, the retroverted unfixed uterus does not spontaneously become anteverted when the genu-pectoral posture is resumed, and the vaginal orifice opened. This replacement of a retroverted uterus seldom happens when the patient is in the knee-breast posture, as any careful observer can notice. The vaginal fingers do not feel the retroverted fundus in this posture, simply because the uterus has receded towards the thoracic diaphragm. By certain manipulations, however, the enlarged retroverted uterus, when not fixed by adhesions, can be replaced."

Two illustrative cases are then given. In the first the retroverted gravid uterus was replaced by injecting air into the rectum in this posture ; and in the second a retroverted sub-involuted uterus was replaced by seizing "the cervix with the volsella," making traction "down towards the perinæum," and carrying "the cervix up towards the sacrum," after failure to replace it by pressing the fundus upwards through the vaginal wall, while the vagina was distended.

They refer to a case given by Mundé, namely, of retroversion of the gravid uterus replaced by full dilatation of the vagina with air by means of Sims's speculum, used when the patient was in the genu-pectoral posture. Mundé thought "the full distension of the vagina with air effected the reposition." But they show how the use of the Sims's speculum, by "hooking up the sacral segment forcibly, may have caused such a tension on the posterior vaginal wall, as to haul the cervix behind the transverse axis of rotation, and allow the heavy fundus to sink down. Thus Mundé practically pulled the cervix back, as with a volsella, and pushed on the fundus."

They, therefore, do not believe in the assertion that "the retroverted uterus becomes anteverted, when a patient in the genu-pectoral posture has the vagina distended with air; nor that the genu-pectoral posture, followed by the opening of the vaginal orifice, is a means of treatment which is followed by full replacement of the retroverted uterus, unless in a small percentage of cases." "The practical uses," they add, "of the genu-pectoral posture seem to us to be more limited than many gynæcologists imagine. For the passage of pessaries, unless in prolapsus uteri, it is not advisable to place the patient in this posture, and we are unable to see what good can ensue from making a patient assume this posture, in order to distend the vagina by passing Campbell's tube, except in the case of congested ovaries."

As I have already said, their results correspond entirely with my own clinical observations. The following cases may be briefly quoted.

Case XX.—*Retroversion of gravid uterus ; failure of the genu-pectoral posture ; replacement by means of the volsella ; Hodge's pessary.*

About ten years ago a patient came under my notice at the Samaritan Free Hospital, with the gravid uterus retroverted. Placing the patient in the genu-pectoral position, I was disappointed to find what Simpson and Hart experienced, namely, that the cervix was drawn up behind the symphysis pubis, almost beyond reach of the finger, while the body remained retroverted, even to an exaggerated degree. I then seized the anterior lip with the volsella, drew it down towards the perinæum, and then carried it backwards and forwards into the hollow of the sacrum, when the uterus at once assumed its normal position. The patient was now placed on her back, and a large Hodge's pessary introduced. There was no return of the Retroversion.

Case XXI.—*Retroversion of gravid uterus with retention of urine, &c.*

Mrs. C——, aged thirty-one, married five years, consulted me on March 6th, 1882. She stated that she had had three miscarriages, of which the last had occurred ten months previously. About three

weeks before her visit, she began to experience some difficulty in passing her urine, and about a fortnight after, retention became complete, so that she was obliged to have recourse to her usual medical attendant, who at once passed the catheter, and continued to do so twice daily until she came to me. On examination I found the uterus enlarged and retroverted, the body filling the hollow of the sacrum. After drawing off about a pint of urine, I placed the patient in the genu-pectoral position, but no manœuvring affected the mal-position, until I had drawn the cervix downwards, backwards, and upwards, as in the former case, and then replacement was at once and painlessly effected. The result was completely satisfactory.

Case XXII.—*Retroversion of three and a half months' gravid uterus; retention of urine, &c.*

On June 27th, 1882, I was consulted by Mrs. H——, aged thirty-three, the mother of one child, fifteen months old. She stated that she had menstruated last in the first week of March. On the 23rd inst., she was first unable to pass her urine, and sent for her "doctor." After taking some medicine prescribed by him, she passed a small quantity of urine, several times, but had since had complete retention, namely, from 6.30 A.M. on 25th to the same hour on 26th, when the catheter had to be used with the result that a "potfull" was drawn off. Had not passed any since then. On passing

the catheter I drew off between 60 and 70 ounces, then placing the patient in the genu-pectoral position, I at once succeeded in replacing the retroverted gravid uterus as in the preceding cases. As the uterus was large I did not deem it necessary to adapt a pessary, and the happy result confirmed this view, for on the following day she reported that she was then able to pass her urine without any trouble, and the uterus occupied its normal position.

Simpson and Hart enforce their views by anatomical considerations, for which I would refer the reader to their monograph. There is, however, one point which seems to have escaped their attention, and that is the part played by the small intestine in supporting the uterus—replaced and unimpregnated. While they hold that no "good can ensue from making the patient assume this posture," as recommended by its advocates, it appears to me that positive harm may result. Some authors maintain that, in the normal condition, no small intestine occupies Douglas's pouch. This is undoubtedly a mistake, as I have already pointed out (p. 75). If then it be true that there is small intestine there ("except at its lowest part," as say Hart and Barbour), it must be evident that one effect of complete distension of the vagina by this method, must be to obliterate the pouch and drive the intestines into the general peritoneal cavity, gravitating towards the epigastrium. On the return of the patient to the recumbent or erect posture, the intestines will

then press upon the fundus and tend to drive it into the pelvis unless supported through the vagina. Nor is this the only effect; for, supposing the patient to be wearing a pessary, then the vagina is so distended, that the pessary lies quite loose in it, and the chances are against its resuming its correct position on change of posture. In my experience it has seemed to do harm—in some cases by allowing the pessary to get in front of the cervix—and for some time I have entirely discontinued the practice.

ANTEVERSION, according to the definition of Gaillard Thomas, "consists in an anterior displacement of the uterus so that the fundus approximates to the symphysis pubis, and the cervix retreats into the hollow of the sacrum."*

As to its frequency, Churchill, nearly twenty years ago, expressed himself thus:—"Anteversion of the unimpregnated uterus . . . . . is said to be much more frequent than has been supposed. But I confess I have seldom met with it to such an extent as to cause inconvenience, except from organic disease."† On the other hand, Thomas holds that "although not so frequent as its kindred condition, anteflexion, it is by no means of rare occurrence. At times it presents itself as an annoying complication of areolar hyperplexia, or fibroid growths; while, at others, it is produced without any alteration existing in the uterine parenchyma."

I have long maintained that Anteversion *per se* is a displacement of no importance, and that as

* 4th Ed. p. 340. † *Op. cit.* p. 405.

it is the least in degree of all displacements, for anatomical reasons which must be evident to every one (and Klob tells us that "as a matter of course anteversion of the uterus *cannot* attain a very high degree"), so it is accompanied with fewer symptoms than any other, and calls least for treatment. I have not met with an instance, for several years, in which I considered the condition to require treatment as such, and I believe that what importance it may possess is due to the pathological condition of the uterus itself, such as sub-involution, chronic metritis, intra-uterine polypus, &c.; on the other hand, judging by the amount of space devoted to the subject, we must assume that Thomas regards it as important, requiring special treatment. Mundé is evidently of the same opinion; for I find that out of forty cases of forward displacement treated with vaginal pessaries twelve were cases of anteversion.*

On this question I find myself more in accord with Emmet, who says:—"I have for many years held the view that an anteversion of the uterus is not a mal-position; and that no degree of version will cause irritation of the bladder so long as the uterus remains in a healthy condition. But whenever the uterus becomes heavy from any cause, it will settle down in the pelvis, and the irritation produced will be in proportion to the amount of traction exerted along the anterior wall of the vagina."†

* Curability of Uterine Displacements. *Op. cit.* p. 789.

† *Op. cit.* p. 310.

Still more thoroughly are my views expressed by Hart and Barbour in the following paragraph :—

"We have described anteversion as one of the displacements of the uterus. The student should note, however, that anteversion is in itself not a lesion but one of the physical signs of metritis, chronic pelvic peritonitis, or pregnancy. It is improbable that the mere anteversion of the uterus causes any distress. The ordinary statement that the uterus when anteverted presses on the bladder, is open to the fatal criticism that the uterus always presses on the bladder, while, so far as mere weight is concerned, there are in the majority of cases, no special symptoms referable to the anteversion of early pregnancy. Any enthusiastic believer in anteversion pessaries is bound to insert them in all cases of pregnancy. Probably in a few years, anteversion will cease to be considered among uterine displacements."*

At the time of the publication of my pamphlet, of so little importance did I regard it that I did not even once mention the name. But as much space is still devoted to it in our systematic works, I have felt it incumbent on me to express my views in full.

No one, therefore, will look to me for guidance as to the mode of treatment of this condition. Such mechanical treatment as I did at one time employ, in reliance upon authority, and in the various forms recommended, proved a failure; and the frequency with which, it will be found, in the preceding cases,

* *Op. cit.* p. 332.

that anteversion has been purposely produced, with the effect of relieving the symptoms complained of, and without the development of new ones, will furnish proof of my assertion, and support my contention.

Here I cannot refrain from adding an illustration, not of what the proper application of a pessary *should* be, but rather of what it should *not* be. It is Mundé's figure, on the authority of Hart and Barbour,—illustrating the mode of action of Gehrung's pessary, a form which finds so much favour with him, as well as Thomas, Fritsch, Schultze, &c.

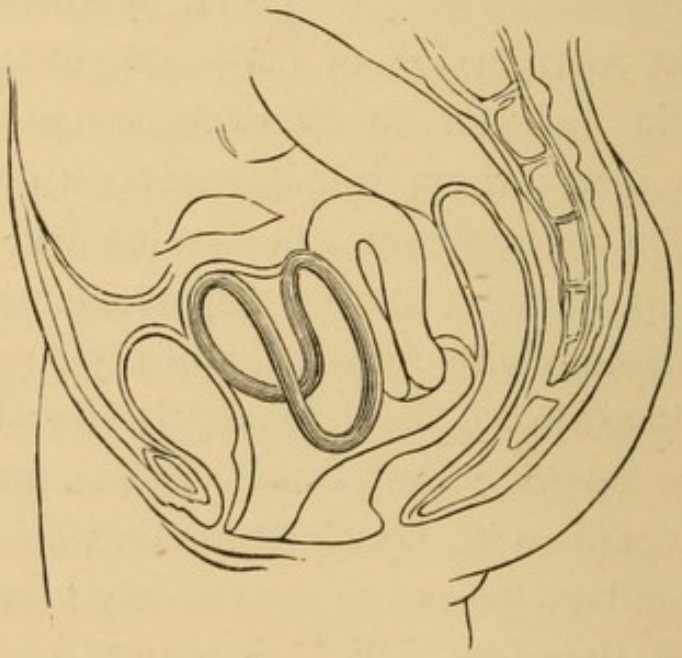


FIG. 12.—GEHRUNG'S PESSARY AS PLACED BY MUNDE.

In this illustration the instrument is represented as lying *between the uterus and bladder* after raising the anterior fornix and separating the connection between the two. From the relations of the parts, as here represented, it would appear that the

instrument can press up the upper part of the anterior wall of the vagina, above the level of the top of the bladder, and nearly as high as the fundus of the uterus, causing the absorption of the cellular tissue between the uterus and bladder. The re-flexion of the vaginal wall on to the bladder near the fundus is a still greater absurdity.

Of all the displacements of the uterus, ANTEFLEXION is the one which has excited the bitterest contention. For, while some maintain that a considerable amount of anteflexion is the natural form of the uterus, others regard it as a true pathological state; while some believe that anteflexion is a very common condition, others hold that it is comparatively rare: and while some ignore it altogether, as destitute of any importance, except from its associated disorders, others regard it as the veritable cause of much disability and suffering to the patient.

The scope of this work has hitherto precluded me from treating of the etiology, pathology, and symptoms of the displacements of the uterus; but in this instance I feel constrained to make such reference to these subjects as may be necessary to elucidate my views as to treatment.

I may at once state that while I regard anteflexion as of great importance, I do not side with either of the extreme views above stated.

It has not been proved that anteflexion is the normal form of the uterus of the adult woman, nor invariably so of the infant, though this view has

been adopted by some writers : it is undoubtedly a pathological or abnormal condition.

This view is strongly supported by Bandl in a paper which has come to hand as I write. He says, "A comparative examination of a great number of uteri of the new-born, of children, and of adults, showed that—

"In the *new-born*, the uterus was partly straight, partly in slight anteflexion, lying . . . . in the pelvic axis.

"In older children, in whom the body of the uterus has acquired greater firmness, that organ is *far more frequently found straight.* Two uteri from fourteen-year-old girls were exhibited. In one of these the axis is straight. . . . . In the second there is a small forward angle of the axis, no simple curvature of the uterus.

"*The straight form of the uterus is frequent as compared with the anteflexed.*" *

I do not believe that anteflexion is so frequent as some maintain ; but that it has been asserted on very insufficient evidence. Herman tells us that, as the result of his investigations, "*in nearly one-half of all nulliparous women the uterus is anteflexed,*" and that of 111 women examined, with a special object, "pronounced anteflexion was present in 53, or 47·7 per cent." † That this is a most exaggerated statement of the case cannot be doubted, and such a result is probably best accounted for by the

* *American Journal of Obstetrics*, Feb. 1884, abstract pp. 198-9.

† Trans. Obst. Soc. London, 1881, p. 219.

mode of examination adopted. For, as Galabin has pointed out, "Herman's statistics might perhaps apply, not so much to uteri which actually had a marked anteflexion, as to those which could be brought into such a condition by pressure from above." * Yet these statistics have been accepted as conclusive by some whose anxiety to prove the innocuousness of flexions has caused them to jump at an extreme statement like this, which so harmonized with their views. On the other hand, I hold that a proportion of 6 per cent., as estimated by Depaul, is rather too high than too low. If Herman had said that in nearly one-half of all nulliparous or *sterile married* women the uterus is anteflexed, I should have been inclined to agree with him. The statistics on this point are of the most unsatisfactory character, the percentage varying from the 6 per cent. of Depaul to the 100 per cent. of Boulard.

I believe they are in error who regard the flexion as of no importance. To show this was the object of Herman's paper; and Matthews Duncan agrees with him, in contending that the flexion causes no obstruction to the escape of the menstrual flow, grounding the assertion on the results of some experiments conducted by himself, which experiments showed that the bending of a rigid tube—I presume within certain limits, *i.e.*, short of diminishing the lumen of the tube—did not retard the flow of fluid through it. That this is a very one-sided

* Obstetrical Society's Transact., 1881, p. 230.

and imperfect representation of the case goes without saying. Dr. Duncan ignores the swelling of the mucous membrane during the menstrual period. Hence an appeal to clinical facts yields a very different answer; and it will be found that they are nearer the truth who maintain that the flexion is the veritable cause of much disability and suffering to the subject of it. How frequently, for instance, anteflexion is associated with sterility is recognized on all hands. The weight of authority also is in favour of the view that anteflexion is very frequently —so frequently as to be almost invariably—attended with dysmenorrhœa of a very characteristic character. Even Herman admits, as a clinical fact, "the undeniably large number of cases of dysmenorrhœa in which the uterus is found anteflexed."* Then again, there is abundant evidence that anteflexion is very frequently associated with constriction at the internal os—either potential or organic—and that in such cases dysmenorrhœa, as well as sterility, is inevitable. It may be true that the flexion does not *directly, in all cases*, produce dysmenorrhœa, or sterility, or both; but that in many cases the flexion, in the words of Scanzoni, does induce "alterations in the structure of the organ," and may therefore be regarded as at least the predisposing cause. Thus, with a well-marked anteflexion, and particularly in the earlier years of menstrual life, there will probably be no dysmenorrhœa,—*i.e.*, of the characteristic kind —if the canal be patulous, as indicated by the sound

* Obst. Trans. 1881, p. 214.

or bougie ; but if the sound enter with difficulty, especially through the internal os, then there will be dysmenorrhœa, severe in proportion to the amount of obstruction ; and this is proved to demonstration by the effect of dilating the canal, even though the flexion be not reduced. In support of this I refer to Dr. Duncan's own practice. But Dr. Duncan tells us that the condition is one of spasm. Then why does he resort to mechanical means to remove it ? As well might he call stricture of the urethra in the male a spasmodic disease. In fact the analogy between these two conditions is complete, as I shall show.

The history of a case of well marked anteflexion with dysmenorrhœa in a married but sterile woman is very instructive. What does such a case tell us ?

It tells us that when the menses appeared for the first time, the patient simply complained of more or less aching, at the commencement of the flow ; that as years rolled on, the pain went on increasing, not as on a graduated scale, but, as it were, by fits and starts, irregularly, or perhaps insensibly, so that at the end of certain periods—say of two or three years—the pain was worse than at the beginning. It tells us that after marriage the pain increased more rapidly, and that marital relations were more frequently attended with pain, and less frequently with satisfaction, as time progressed ; that the pain, at first quite bearable, of an aching character, and not interfering with the duties or pleasures of life, had at last increased to such an extent that, for

some hours at least, the patient was rendered helpless, perhaps made to writhe in agony, the attack often ending with a fit of vomiting; that the pain had become more distinctly intermittent in character, and that relief coincided with the full establishment of the flow. It tells us that at first the flexion simply retarded the flow, producing this aching pain; that the frequent recurrence of this retardation caused stasis of blood in the vessels—in other words a state of passive congestion; that this congestion, affecting the whole organ and intensifying the physiological congestion, caused extreme turgescence of the mucous membrane; that this turgescence, diminishing the calibre of the canal, especially at its narrowest part, viz., the internal os, produced a true constriction or obstruction from within; that as this congestion became more and more confirmed, the flow was more and more impeded and the pain increased *pari passû*. It tells us that in the early stage there was no leucorrhœa, but that with the increase of pain and the incidence of congestion there was decidedly a milky-whitish discharge from the genitals; and that in the last stage this discharge increased in quantity, and at the same time assumed a yellowish appearance, leaving on the linen a distinctly yellowish stain. It tells us that, at first, the flow presented the normal character as to colour and fluidity, but that as the dysmenorrhœa became more pronounced, it became darker and more turbid, until at last it came to resemble broken-down blood-clot rather than menstrual fluid,

in some cases even becoming offensive from long retention. And it tells us that at first the cavity was of normal size, but at last had become larger than normal.

These are the local effects of the flexion, and the period of time embraced, say, from eight to ten years, which may be divided into three stages.

Now, if we were to seek an explanation of these phenomena, we should find that in the first stage examination would reveal the existence of an anteflexion, but the uterine canal sufficiently patulous to admit the sound easily (and equally so the ready escape of the menstrual flow); in the second the sound would enter with some difficulty, causing pain as it passed the internal os, and its withdrawal would probably be followed by a few drops of blood; while in the third the sound would encounter still greater obstruction, producing severe, almost intolerable, pain and perhaps vomiting, especially if an attempt were made to dilate with the bougies. In this case there would probably be considerable bleeding. In all these the pain would be likened to that characterising the menstrual flow at its worst.

This is no fancy picture, but might be taken as the history of many cases, as it is of one. It might be very much heightened by depicting the reflex symptoms arising from the local affection.

All these phenomena point to the existence of a gradually progressive change in the structure of the organ—a change which partakes of the

inflammatory process in a subacute form, and resulting in that condition which is variously described as "hyperplasia," "hardening," and "thickening" of the tissues. So decided is this in some cases of long standing, that the tissues at the internal os creak under the knife "like gristle" in the operation of division. And that the site of the pain is the internal os is easily proved, as in the case briefly described at page 162.

Some gynæcologists ignore the existence of an internal os. Yet nothing is more easy of demonstration and proof. Thus, in the later months or weeks of pregnancy, and before the actual setting in of labour, the well defined circle of the os cannot be mistaken by any careful and thoughtful observer. In this I am happy to find myself in accord with Drs. Matthews Duncan, and Henry Bennet. This may also be seen in a case of abortion before the ovum has entered the cervical canal. Still more evident is it when one has to extract the adherent placenta of an abortion, some days after escape of the fœtus and liquor amnii. Perhaps the most marked instance of this well-defined condition I have seen was in the case of a small fibroid which I had to enucleate from the fundus uteri. In this case I was obliged to dilate the internal os repeatedly by means of Molesworth's dilator before I could complete the enucleation and finally deliver the tumour. Again, if into a healthy cervix a laminaria tent be introduced and left for twelve hours, it will be found, at the end of that

time, uniformly dilated; but if there be organic stricture, as is so often met with in the severer cases of dysmenorrhœa with anteflexion, even twenty-four hours will not always suffice to effect complete dilatation, and in many great difficulty will be experienced in extracting the tent at all. In several cases I have had to leave the tent in for forty-eight hours. When, however, it is possible, though with great difficulty, to extract it at the end of twenty-four hours, it will present the appearance shown in Fig 13, which is an exact representation of such a

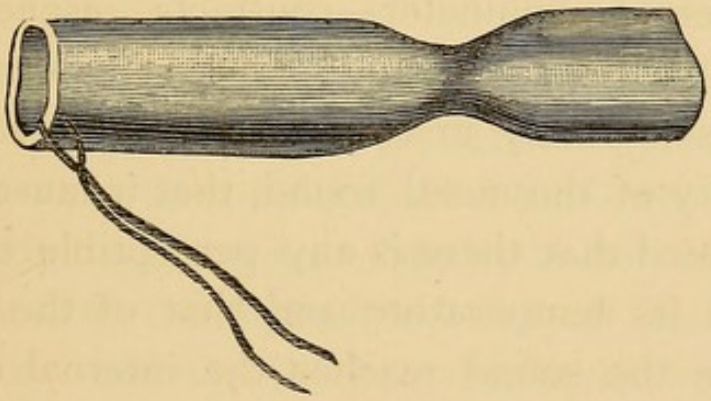


FIG. 13.

tent. The original size of the tent was No. 14, French gauge: the ends were dilated to thirty-four and the constricted part to eighteen. Here the constriction corresponds to what is usually called the internal os; and in my experience this is the invariable site. Many gynæcologists have described a similar result, and have thus testified to the correctness of this description.

Yet with all this evidence Fritsch tells us that "Stenosis of the internal os has now gone out of

fashion—even those of the external orifice are only operated on in order to facilitate the escape of the cervical mucus. Anyhow it is very difficult to prove the (existence of) stenosis of the internal os *i.e.*, to be able to maintain with certainty that any resistance felt is (due to) stenosis." In this I entirely disagree with Fritsch; for it is not more difficult to prove the existence of stenosis of the internal os than to prove the existence of a stricture of the male urethra. Apparently quoting the views of Bennet, he goes on to say, "It has even been asserted that the muscular tissue of the uterus—the internal sphincter—contracts, especially on contact with a cold sound."* I cannot but think that this is purely imaginary, for, such is the conductibility of the metal sound, that it must be very rare indeed that there is any perceptible difference between its temperature and that of the body by the time the sound reaches the internal os, if the precaution—which I assume to be usual—be observed of warming it by rubbing in the hand, or dipping it in warm water.

Here, then, we see a strong—even complete—analogy between stricture of the uterus and stricture of the male urethra as the result of the inflammatory process: and the analogy holds good in the matter of treatment, even to the difference of opinion and practice. Some gynæcologists use the bougie, as was at one time the method of Surgeons in the case of the stricture of the urethra: others resort to the

* Fritsch. Die Lageveränderungen der Gebärmutter, p. 37.

knife and divide the strictured portion just as the Surgeon either forcibly ruptures, or with a knife divides, the male stricture.

It is denied, on the evidence of specimens of anteflexion of the uterus, to which no history is attached, that there is any enlargement of the cavity in a severe case of anteflexion with dysmenorrhœa. I affirm the contrary, as the result of very many observations on the living subject. The normal length of the virgin uterus is generally accepted as $2\frac{1}{2}$ inches at the most. In the cases under consideration I invariably find it from $2\frac{3}{4}$ to 3 inches and even more. Herman bases much of his argument on the absence of any anatomical evidence of obstruction, and he demands that actual distension of the uterus should be demonstrated by a post-mortem specimen, *i.e.*, that the uterine cavity should present the appearance of an elastic or hollow ball. Surely, he does not seriously mean any such thing! In no case of enlargement of the uterine cavity, unless it be occupied by some body such as a polypus, fibroid tumour, or placenta—does it present this appearance. In sub-involution the uterine cavity is often enlarged to double its natural size, and yet there would be no evidence of dilatation, in the sense implied by Herman. More extraordinary is the statement of Matthews Duncan, who, in supporting Herman's views, referred to a "specimen of anteflexion with *complete atresia or closure* of the cervical canal," shown by him lately to the Obstetrical Society of London, in which he

said "there was no spur and no dilatation of the uterine cavity." Does Dr. Duncan wish us to understand that the patient menstruated in spite of the *complete atresia or closure* of the cervical canal and at the same time that the menstrual fluid was secreted and did not distend the uterine cavity though it could not possibly escape in consequence of the closure of the canal? On this question Galabin* appears to me to have fully exposed the fallacy of Herman's argument on theoretical grounds, while more recently Mr. W. S. A. Griffith has afforded direct anatomical proof in a specimen which he exhibited before the Obstetrical Society of London, January 10th, 1883. Of this specimen Mr. Griffith says: "The bend is situated just at the junction of the cervix and body, and above it the cavity is considerably dilated and was found to contain the remains of a clot of blood. The specimen is probably unique in this point, and is of special interest in giving the positive anatomical proof of the possibility of such a condition, which Dr. Herman said in his paper last summer was wanting."† Along with Duncan, I do not admit the existence of a spur at the angle of the flexion and in the anterior wall. Such a condition could only coincide with distension of the uterine cavity proper. I cannot even imagine such a thing.

The specimens that have been exhibited have effectually disposed of the theory that there is a

* Trans. Obst. Soc. London, p. 229, 1881.

† Trans. Obst. Soc. Vol. XXV. p. 7.

thinning of the anterior wall at the point of flexion. On this point Mr. Griffith says: "The walls of the uterus . . . . . exhibit the condition described by Dr. Bantock, viz., a thickening of the concave side of the bend, probably from a crowding together of the shortened but thickened muscular fibres at this point; there is no marked thinning of the convex wall of the uterus, and it is probably correct to say there is none at all."*

Anteflexion, which, next to Retroversion, is the most frequent of all the displacements of the uterus, consists, in the words of Gaillard Thomas, "in a bending forwards of the organ, so that the fundus, the cervix, or both, are bent more or less sharply forwards"†

Different authors adopt different modes of classification; thus Graily Hewitt classifies cases according to:

"1. Degree of flexion, first, second, and third . . .

"2. Degree of rotation.

"3. Degree of descent of uterus as a whole.

"4. Degree of resistance offered by the uterus itself to unbending or replacement.

"5. Presence or absence of (*a*) congestion, (*b*) enlargement."‡

Gaillard Thomas divides this condition into "three varieties—first, corporeal flexion; second, cervical flexion; third, cervico-corporeal flexion.

"1. The cervix being normal in position the body is flexed.

* *Op. cit.* p. 6. † *Op. cit.* p. 410.

‡ *Op. cit.* Vol. I. pp. 298–9.

"2. The body being normal in position the cervix is flexed.

"3. Both are flexed forwards."

"In addition to this," he says, "there is a rare form in which the cervix is flexed forwards and the body backwards, but it is difficult to represent the axes of this variety in a diagram."* With reference to this form I would at once remark that there must surely be some mistake in the description; for as it stands, it is, to me at least, utterly incomprehensible by what means the cervix can be *flexed forwards* and the body at the same time *backwards.*

In these two classifications there is nothing in common. Hewitt's three degrees even do not correspond with Thomas's three varieties; the former admits "variations in the position of the flexion," the latter places them all at the junction of the body with the cervix, but he ignores those cases in which, together with anteflexion of the body, there is posterior rotation of the whole organ. While Hewitt's classification is thus more complete than that of Thomas, they both ignore those cases in which constriction of the internal os is associated with the flexion.

A third classification is that of Roper, who divides the cases into (1) Congenital (2) Acquired. "The one class depends on congenital malformation or imperfect development, the uterine texture being healthy; the other on morbid changes in the uterine

* *Op. cit.* p. 411.

tissues or appendages."* While I do not see the utility of the classification, I agree with Roper in regarding anteflexion in the virgin or nullipara as congenital, and that of the fertile woman as acquired ; and I am quite in accord with him when he says, " My own experience of the acquired form of anteflexion is that it is very rare."

Thomas thinks his three varieties are " neither arbitrary nor unnecessary," and he is of opinion that " no one can intelligently treat anteflexion without regard being had to the variety of the disorder to which he is called upon to adapt his mechanical appliances."† The latter may be admirable as a principle, but it involves the idea of a perfect classification. In these classifications we have either too much or too little ; and I hold that they are not only " arbitrary and unnecessary," but also useless for practical purposes. Of what avail is it to be able to say that a case is of Thomas's first, second, or third variety, or Hewitt's first, second, or third degree ? It is impossible to assign the boundaries to these varieties and degrees. They probably exist, with more or less definiteness, in the minds of these authors, but they are not capable of being conveyed to the mind of another. For all practical purposes it matters not whether the flexion be of the first, second, or third degree, and associated or not with posterior rotation, nor whether " the fundus, the cervix, or both be bent more or less

* Dr. Geo. Roper. Trans. Obst. Soc. of London, Vol. XX. p. 304.

† *Op. cit.* p. 410.

sharply forwards." The principle of treatment is the same, *i.e., only an intra-uterine stem can straighten a flexion.* But *it is* of importance whether there be congestion of the whole organ, and whether there be organic stricture of the internal os.

Practically, then, I admit the three varieties of Thomas—though they are not always distinguishable with accuracy; I agree with Hewitt that the flexion varies in intensity; that it is *sometimes* associated with posterior rotation, and more often with congestion and enlargement; and, while attaching no practical importance to the distinction, I am in accord with Roper in dividing cases into congenital and acquired. But I differ from all in forming another variety—namely, in which organic stricture of the internal os with congestion complicates the flexion.

It will be convenient now to discuss the principles and details of treatment, and I shall assume that we have to do with the simplest form of anteflexion; that is, one in which the cervix occupies its normal position, but the body is bent forwards on to the bladder; in which there is no appreciable congestion, no excoriation, and no organic constriction of the internal os. Of course I assume also that the patient suffers from dysmenorrhœa, that in consequence of this she has sought advice, and that the examination has revealed the flexion as the probable cause. What is the appropriate treatment? Graily Hewitt will tell you to apply his cradle pessary, Thomas, Fritsch, and others will recommend some

form of vaginal pessary as a rule, and in rare cases the intra-uterine stem, while Duncan, Bennet, and others will advise you either to leave it alone or to use the dilators.

Now I have long maintained that no vaginal pessary yet constructed can undo a flexion, and I have the satisfaction of finding my views reflected in the most recent work on Gynæcology. Thus, Hart and Barbour, describing "the effect on

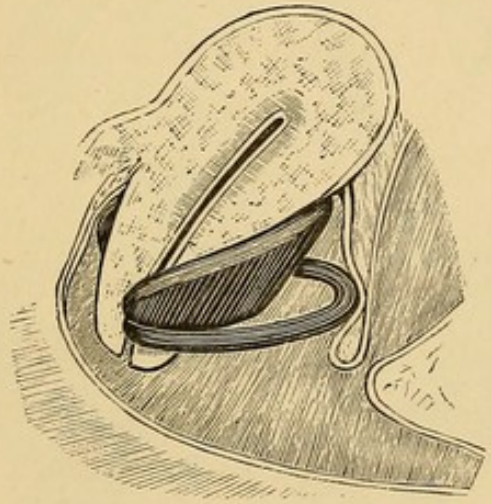


FIG. 14.—"THOMAS'S ANTEVERSION (AND ANTEFLEXION) PESSARY AS IT APPEARS IN THE VAGINA."

uterine position of digital pressure in the vaginal fornices," say, "If pressure be made in the anterior fornix—

"1. The uterus becomes elevated and slightly rotated backwards because the cervix is pulled forwards—

"2. If the uterus be anteflexed, the flexion is not diminished."

"By pressure on these fornices, therefore, we only act on the cervix, unless the uterus be very much

retroverted or anteverted. *The body* of the uterus is acted on only indirectly, through its union with the cervix.

"Consequently no vaginal pessary can undo a flexion of a retroflexed or anteflexed uterus."*

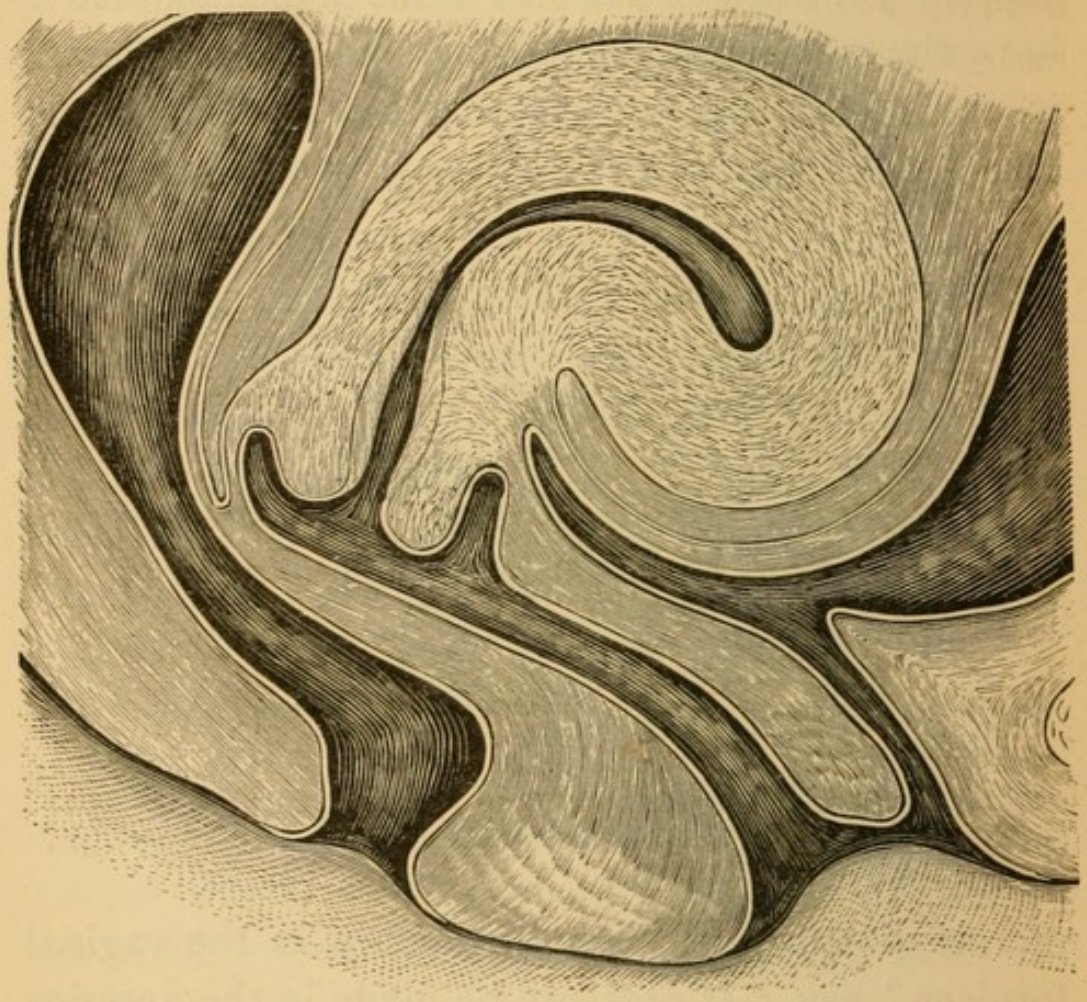


FIG. 15.—ANTEFLEXION OF UTERUS (2nd or 3rd degree?) (Hewitt.)
"The position of the adjacent organs being also depicted."

If we look at the illustrations employed by Hewitt and Thomas to enforce their views we find impossible relations represented. For instance, Fig. 14 is employed by Thomas to illustrate the mode of action of his pessary for anteflexion *or anteversion.*

* *Op. cit.* pp. 77–8.

In this there are numerous errors. Thus, not to lay stress on the dilated state of the vagina, the urethra is obliterated, the connective tissue between the uterus and bladder has disappeared, the bladder is separated from the uterus, and the peritoneum dips down in a deep sulcus between the two.

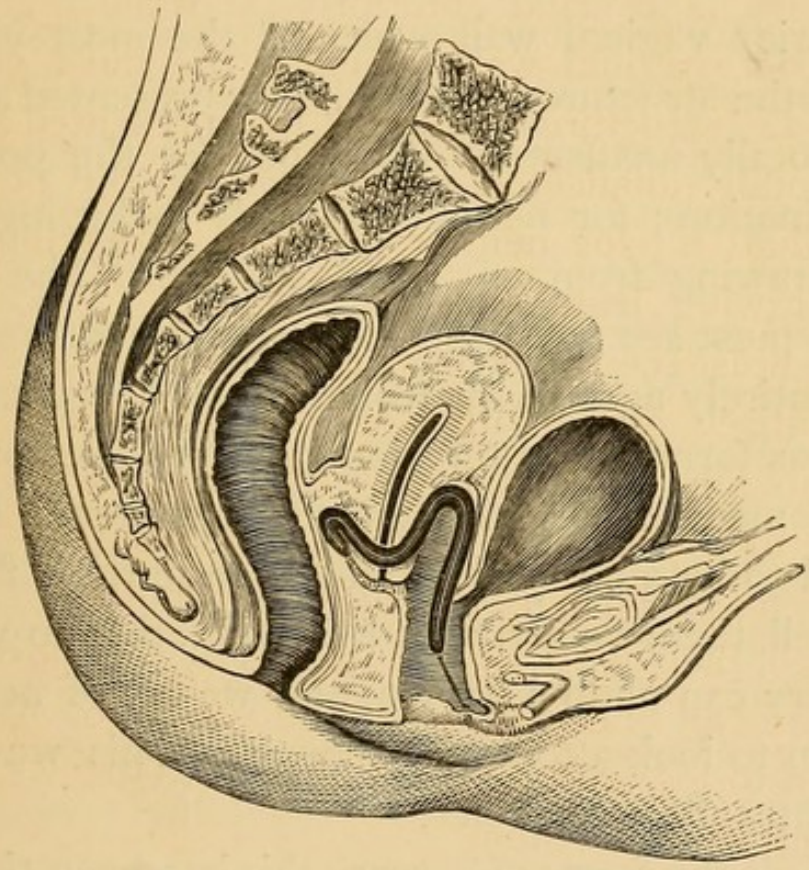


FIG. 16.—GRAILY HEWITT'S ANTEVERSION (AND ANTEFLEXION) PESSARY. (Thomas.)

Now I borrow from Graily Hewitt, and Fig. 15 gives his views of the anatomical relations in a case of anteflexion.

Admitting for the sake of argument that this is a correct representation of these natural relations, does it seem possible to undo this flexion by raising the fundus *through the vagina?* I maintain that it

is not. The next illustration, Fig. 16 shows, in the views of Hewitt and Thomas, how it is done.

To my mind it is an illustration of "How not to do it." For here again the urethra is obliterated by retraction into the vagina, the anterior lip is lengthened to four times its natural length, all the pressure is exerted anteriorly, and the rectum or posterior vaginal wall, which is the most yielding of all the structures involved, is represented as rigid and totally unaffected. So much for the power of imagination; for neither pretends to having made his drawing from an actual section. The merest Tyro must see the errors here committed.

I entirely agree with Roper when he says, "The various forms of anteflexion pessary, most of them some modification of Hodge's instrument, I have found to be quite useless and often hurtful."*

Well, then, we arrive at this—viz., that no vaginal pessary can undo a flexion, and we are of necessity driven to look after other means. This we find in the intra-uterine stem.

Of all the forms of pessary this has been the most maligned (both in theory and practice). First employed and after a while abandoned by Velpeau, taken up and subsequently rejected by Amussat, and again receiving an impulse from the warm advocacy of Simpson, of Valleix, and others, this instrument has gone through many vicissitudes of fortune, experiencing in turn the highest encomiums and the most sweeping condemnation. Yet it has

* *Op. cit.* p. 312.

never been forgotten; for, in the words of Thomas, "None could hesitate to indorse the sentiment expressed by Malgaigne in the discussion upon the subject in the Academy of Medicine in Paris in 1852, that 'a treatment which Amussat, Velpeau, Simpson, Huguier, and Valleix had tried, cannot, should not, be considered as repugnant to common sense.'"* Notwithstanding the opposition it still encounters, chiefly from those who have never used it, and who consequently do not understand the subject, it is at the present day more in favour than at any previous time. Of the more enthusiastic advocates I may mention the names of Wynn Williams, Routh, Meadows, Chambers, Coghill, and Hugenberger, and of the more cautious Graily Hewitt, Thomas, Mundé, Schultze, Hegar and Kaltenbach, and Fritsch. (I have omitted the name of a distinguished American gynæcologist because I wish to give prominence to the following remarkable recantation which does credit to the heart and head of its author. In the year 1880 Dr. William Goodell, of Philadelphia, thus wrote: "Some four years ago I wrote a series of articles for the *Medical and Surgical Reporter*, of Philadelphia, in which I termed this instrument a good one, a very good one—*to watch*. I had then just passed through an unpleasant experience with it in two cases. . . . . With this unhappy experience, fresh in my mind, I was led to condemn, in these articles, the use of the intra-uterine stem. But, since then, a *riper experience*

* *Op. cit.* p. 427.

has taught me a good deal about this pessary, and has wholly changed my views with regard to its use. I now hold that there are certain stubborn cases of anteflexion, and for the matter of that, *of retroflexion too*, which can be satisfactorily treated in no other way than by this stem. . . . . I now, however, take certain precautions which I did not take before—precautions which close observation has taught me needful, and which give me far greater confidence."*

Such are the views of Dr. Goodell, and I doubt not that a still *riper* experience will lead him to the further extension of the use of this instrument, and that he will look upon it as the proper treatment in all cases of Anteflexion, *and Retroflexion*, as far as the flexion is concerned.

Nor should I omit to mention here that the late Dr. Marion Sims had, in *his* riper experience, come to regard this instrument with more favour than his writings would lead us to believe.

That the use of the stem should be hedged round with precautions scarcely needs the saying. Omitting such as common-sense would dictate, it should not be used during the existence of congestion of the uterus, or of inflammatory disease in the pelvis, whether of the ovaries, tubes, or broad ligaments; it should not be used unless there is a tolerable certainty that there is no chronic disease of the tubes; it should not be used when there is organic stricture of the internal os, until after division of

* *Op. cit.*, p. 160.

the stricture, and then *not until the parts have healed up;* the stem should measure half-an-inch less than the uterine cavity; and, *if possible*, it should be introduced at the home of the patient. Evil results have followed from the non-observance of each of these precautions. I would lay special stress on the necessity of the most careful examination of the tubes, and would lift my voice against the practice of introducing a stem immediately, or within a few days, after the operation of division of the cervix. These points will be illustrated in the following selection of cases.

Cordially agreeing with the principle enunciated by Thomas, namely, that "no one can intelligently treat anteflexion without regard being had to the variety of the disorder," &c., though regarding his classification as useless for practical purposes, I now proceed to illustrate my views by a statement of their practical application.

Assuming, then, that we have to treat a case of the simplest form of flexion, what is the proper treatment? To this question I reply—The intra-uterine stem. Then, which is the best form of instrument?

Here we have a choice, namely, in the simple stem, such as that employed by Simpson, and made either of metal or vulcanite, or glass and vulcanite, or of soft india-rubber; of Chambers' modification of Wright's stem; or of my own stem; and the compound instruments of which those of Routh, Wynn Williams Fig. 17 and Meadows (see Fig.

11) are the best. All these instruments are warmly recommended by their inventors, but my own experience has taught me to give the preference to the instrument of Meadows.

In many cases, however, as I have already pointed out, the cervix is displaced forwards in the vagina so that the posterior cul-de-sac is almost obliterated. In such a case the simple stem will retrovert the uterus unless care be taken to keep the cervix in position. In my earlier cases it several times happened to me to find the stem expelled after a few days, and for a while I was at a loss for an explanation. Nor did any of the text-books assist me in the matter. Careful observation, however, furnished it in time, and I was fortunate enough to note the process in its several stages, so that at last it became easy to understand how retroversion of the uterus must necessarily lead to the expulsion of the instrument. This process was described by me ten years ago in these words—"Dr. Savage asks for an answer to the question, 'Why does the stem remain *in situ* in some cases and come away in others?' My experience answers it thus:—If the uterus become anteverted on the introduction of the stem, the pressure of the posterior wall of the

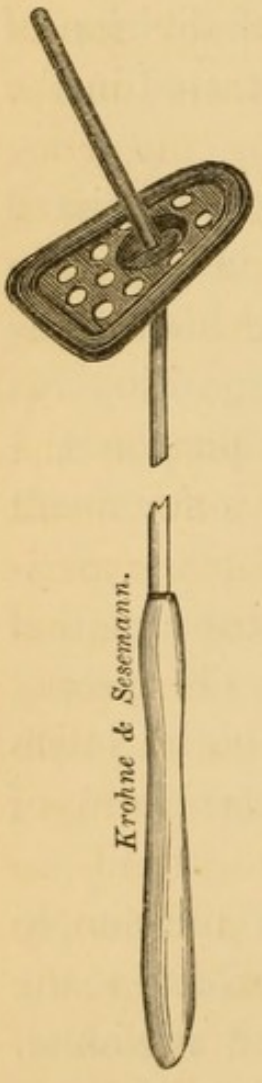


FIG. 17.—WYNN WILLIAMS' STEM AND SHIELD.

vagina keeps it *in situ;* if, on the contrary, the uterus become retroverted, the bulb is exposed to the contractile action of the vagina, which, in the downward and upward movements of the uterus in the act of respiration, permits the descent of the bulb, but prevents its return, and this, aided by the expulsive efforts of the uterus pulls out the stem. The same thing happens, and with greater intensity, under a fit of coughing, or from a sudden jerk—as on falling on the buttocks—which forces the uterus further into the vagina; then, on its return, the bulb is either retained by the contraction of the vagina, or by hitching against a fold of the mucous membrane."* Further experience has confirmed the correctness of this explanation.

To obviate this accident I was at first in the habit of using a Hodge's pessary; but the result was often unsatisfactory. Wynn Williams, experiencing the same defect, invented the vaginal pessary with diaphragm, which goes by his name. At first the diaphragm was made plain, but the bulb slipped over it and did not prevent retroversion: then he added the cup to retain the bulb in position. I tried this method, but in addition to other objections, I found it difficult to keep the vagina clean and to prevent the accumulation of menstrual discharge, so that when Meadows' compound stem was brought under my notice I at once

* *Obstetrical Journal of Great Britain and Ireland*, Vol. ii. (Apr.) 1874. p 7.

recognized its advantages, and, for several years, I have used no other.

The advantages possessed by Meadows' instrument are these, viz., that while it allows of a certain amount of movement, both lateral and antero-posterior, it exercises more control, and, provided the vaginal frame retain its position—being of appropriate shape and size— and the india-rubber band do not break, the uterus cannot become retroverted; that, as the frame projects only an inch behind the plane of the stem, the cervix is kept well back and in its natural relation with the posterior vaginal wall; that the vagina is more easily kept clean; and that the stem may be set at any angle that may be desired. In the case of all the other compound instruments, such as those represented by Wynn Williams, Routh, Thomas, Hewitt, Fritsch and others, the cervix is kept too far forwards, while there is no certain control over the posterior movement of the uterus. The latter defect was the great objection to the combination of stem and Hodge's pessary, and is illustrated in the following:—

Case XXIII.—*Very acute anteflexion; severe dysmenorrhœa; failure of Stem and Hodge's pessary; Meadows' compound stem. Cure.*

Mrs. ——, aged twenty-eight, married six-and-a-half years without having become pregnant, came

under my care on October 3rd, 1876. Menstruation began about fifteen, and had always been accompanied with pain, but not such as to prevent her getting about during the period. Since marriage the pain has gradually increased so that now, when at its worst, it is indescribably severe. She adds that she is quite unable to do anything, and can scarcely "put her feet to the ground." The flow usually lasts for about five days, and the quantity is rather excessive, usually requiring about one dozen napkins (about twenty for the last period). For several days before the period feels greatly depressed. As soon as the period ceases, she has relief for a week and usually about the eighth day after, she suffers from severe bearing down pains, accompanied by the discharge of some mucous. Frequent micturition attends the period, but is scarcely troublesome in the interval. As a rule has no "whites," and with the exception above noted feels very well. Nor does her appearance belie this. About a week before the period begins to have warning of the next, in the form of "violent" headache, depression of spirits, and frequent attacks of nausea. During the period is often *very* sick.

As a rule the appetite is good, but during the period is not; the bowels are usually regular.

"On examination the uterus is so sharply anteflexed that when the finger is passed into the flexion with the palmar aspect on the cervix, the body can be distinctly felt pressing on the dorsal

aspect, and it is quite possible to trace the curve along the sides of the uterus. There is some tenderness on lateral pressure, and pain on sudden impulse. The sound would not pass until I had straightened and fixed the uterus. As seen through the speculum the cervix appears much congested, but there is no excoriation, and no discharge from the os."

October 9th.—Punctured the cervix drawing 1 to 2 ounces of blood.

October 10th.—After pulling down the uterus with the volsella first, I passed the sound with difficulty, and causing severe pain as it entered the uterine cavity, and then tried to introduce a small laminaria tent. In this I failed, but afterwards succeeded on keeping the sound in for ten minutes. Morph. gr. $\frac{1}{3}$ subcutaneously.

October 11th.—Removed the tent which already lay half in the vagina, and well dilated.

October 12th.—Introduced one of my stems—Morph. gr. $\frac{1}{3}$.

October 13th.—Uterus with stem retroverted: replaced.

In the evening the patient was complaining of pain and I found the uterus again retroverted. Introduced a small Hodge's pessary, nearly straight, apparently keeping uterus in good position.

October 14th.—Uterus in fairly good position.

October 15th.—A coloured discharge, probably menstrual; no pain to speak of.

October 23rd.—The period continued till the 21st, quantity not more than usual; none of the old pain, and patient very grateful for the relief. On examination, stem pointing to the vulva, and on removing the Hodge's pessary, it was found to be only partially in the uterus. I at once extracted it also and substituted a Meadows' compound stem, of the presence of which, after a few minutes, she was quite unconscious.

October 26th.—Uterus in very good position; no coloured discharge now to speak of: no pain.

November 21st.—Menses appeared on the 13th and continued for forty-eight hours as a mere "show"; from the 15th to the 17th the flow was rather free, with some clots—yet none so free as previous to the introduction of the instrument—and on the 20th it ceased. No pain during first two days, but on the 16th and 17th, and, although of the same character as formerly, yet it was not to be compared in severity. Is not now conscious of the presence of the instrument.

For the last two or three weeks has scarcely had a night's rest, and has undergone much mental distress through the drunken habits of her husband; has suffered from headache. She has, however, escaped the usual symptoms preceding the period.

December 10th.—Removed the pessary, which has produced no irritation. Patient feels altogether better, and has none of the symptoms formerly preceding the period, though the next is due to-

morrow, appetite good, bowels regular, no nausea, no pain anywhere.

January 31st, 1877.—Period appeared on the 13th ult., and lasted about five days, without any pain whatever. On the eighth day after, had a slight return of the old bearing down pain. The last menses appeared after an interval of three weeks, absolutely without pain, but at the end of a week from the cessation she had a return of the old pain accompanied with a "good deal of whites," for several days. Both ceased together. Has no pain now, and no discharge. Her domestic relations are in the same unsatisfactory state.

Soon after this, the patient was obliged to leave her husband, and I saw no more of her until I met her accidentally at the house of a relative where I was visiting two years ago. I then learned that the dysmenorrhœa had not returned, and I ascertained that the flexion had been cured.

This case presents several points of interest. It shows that the flexion with its attendant congestion was the cause of the dysmenorrhœa; that there was no organic constriction of the internal os,—for the tent was equally dilated,—and the acuteness of the bend alone obstructed the introduction of the sound and tent; that the use of the stem removed the dysmenorrhœa, and that although worn for a very short time the result was permanent,—far exceeding my most sanguine expectations; and it illustrates the inefficiency of the combination, in separate

pieces, of the uterine and vaginal supports, and the mode in which the stem is expelled.

Another case—of which, however, I am unable to find the notes, and of which I have been recently reminded in a very gratifying way—was that of a young lady who was under my care some five or six years ago, the subject of severe dysmenorrhœa with anteflexion. In this case I used the combination of stem and Hodge's pessary. The patient resided in the country and after being under my immediate notice for a few weeks returned home. At the end of twelve months during which she had no dysmenorrhœa I removed the pessaries, but was disappointed to find the uterus somewhat retroverted. However, no harm resulted, for marrying in 1882 she was delivered of a fine boy in the early part of 1883, having experienced nothing unusual either in her pregnancy or confinement.

There is another variety in which, along with anteflexion there is posterior rotation of the organ. This is a very rare form and at the time of the publication of my pamphlet I thought I was alone in describing it. No text-book, that I had then consulted, had any notice of it. I had not seen Graily Hewitt's 3rd Edition, in which I now find it was described. At the present day it is recognized also by Mundé and Fritsch. How impossible it must be to treat such a condition by means of the vaginal pessary must be evident. Happily, however, we have at hand a method to which it is as amenable

as the most simple form, and that is the compound stem.

The following case is reproduced :—

Case XXIV.—*Anteflexion, with posterior rotation; congestion; dysmenorrhœa; failure of combined uterine and vaginal pessaries; Meadows' compound stem. Cure; pregnancy.*

S. H., aged twenty-three, single, came under my care in the out-patient department of the Samaritan Free Hospital, on April 6th, 1875. Menstruation began at the age of sixteen, and for the first few years was not sufficiently painful to draw special attention to it. For the last ten months complaining of a constant bearing down in the hypogastrium and pain in the left groin. The periods recurred with a clear interval of three weeks, and usually lasted four to five days. For a day or two before the flow she suffered from pain of a special character. For the first day of the flow the pain was especially severe. After that, it gradually decreased, and finally ceased with the flow. There was a free, glairy discharge, and marked congestion of the cervix. She also complained of frequent frontal headaches. Her appetite was tolerably good, and the bowels regular, but she had frequent attacks of what she called "spasms." On examination I found the hymen intact and the

vagina very small. The os uteri was directed against the anterior vaginal wall, and the cervix felt somewhat flattened. The body of the uterus could be felt through the posterior cul-de-sac for some distance, so that at first I thought I had before me a case of retroversion. Firm upward pressure in front of the cervix, however, revealed the presence of the fundus uteri there, and the finger detected the well-marked concavity formed by the anteflexion. Thus the uterus was anteflexed and retroverted at the same time, the body lying low down in the hollow of the sacrum. Backward pressure on the cervix caused the uterus to revolve, so that the fundus was more readily felt in contact with the back of the finger. Having observed this condition before, I now recognized the true nature of the case. The patient was contemplating marriage, and requested me to advise her. I had no hesitation in putting my veto on such a proceeding, being well aware of the injurious consequences of the married state in cases of anteflexion. I kept the patient under treatment for over three months, namely, till July 20th, with some relief to the general symptoms. The congestion was decidedly less, and the leucorrhœa had well-nigh ceased, but the deviation continued in no way altered. She returned on October 29th, having relapsed into her former state, and, after a little persuasion, I got her to consent to the local treatment which I formerly proposed. She accordingly entered the hospital on December 13th, just after a

period. Next day I introduced, with great difficulty, and not until I had pulled the uterus straight, a fine laminaria tent. On the following day it was well dilated, and half extruded from the uterus. I gave her a day's rest, and on the 17th I introduced one of my stem pessaries without difficulty, and left the uterus in good position. On the 20th, as the patient was feeling uncomfortable, I again examined her, and found the uterus retroverted, so that the bulb of the stem was near the vaginal outlet. I then introduced a long S shaped Hodge's pessary, apparently with the desired result, and the patient was relieved. On the 31st the patient got an attack of ulcerated sore throat, with considerable fever, through which she passed satisfactorily. During this attack, be it remembered, she was wearing the two instruments. On January 1st the menses appeared and disappeared on the 4th. All she felt was a little aching in the back. On the latter day I made the following additional note: "Patient now sitting up; no pain of any kind."

January 7th.—Uterus a little inclined backwards and to the left side; no discomfort in any position. On the 8th she returned home. On January 21st she again came to the hospital, where she was seen by Dr. Kuhn, of Geneva, who confirmed my diagnosis as to the existence of the slight displacement above mentioned.

February 11th.—Last period, after an interval of three weeks, and for about three days. No pain during the flow, but an aching and fulness in the

groins for about a day before. Continues to follow her usual occupation in the Government Clothing Establishment, and is not conscious of the presence of the instruments.

March 10th.—Menstruated again from 1st to 4th without pain ; quantity moderate. The uterus being still in the same position, I took out the Hodge, made it nearly straight, and re-introduced it. At the end of a fortnight I removed both instruments.

April 29th.—Uterus threatening to return to its old state. Introduced a Meadows' compound stem, which kept the uterus in admirable position. I, however, made the following note : " Probably too large."

May 3rd.—Complaining of pain down the thighs, particularly the right. Substituted a smaller instrument, which produced no discomfort.

I saw the patient several times up to August 10th, when I removed the pessary, leaving the uterus in very good position. Her general health was then very good, and her headaches had quite disappeared. I recommended her to get married without delay, and this was effected on the 18th of November. She menstruated regularly, with an interval of three weeks, *without pain of any kind*, and for the last time in the end of January, 1877. During her pregnancy, which she expected to terminate at the end of September, she enjoyed most excellent health. Her own words are (referring to the latter months), " I was never better in my life." (This patient was delivered of a fine female child

on October 16th, 1877, and is now (1878) in excellent health). 1884.—I have not since heard of her.

The following case is of the same kind :—

Case XXV.—*Anteflexion with retroversion (posterior rotation) ; dysmenorrhœa ; Meadows' stem. Cure ; subsequent marriage and pregnancy.*

Miss M——, aged twenty-seven, was sent to me on June 16th, 1882, by Dr. Griffith of Queen's Park, and consulted me as to the advisability of her getting married. I ascertained that menstruation began about thirteen, that she had always suffered pain at the time, chiefly the first few hours, and that as she had got older the pain had become more severe, so that now it made her "feel very faint and bad," and "usually very sick." On examination the uterus was found very sharply anteflexed, with posterior rotation, to such an extent that the os was tilted against the anterior vaginal wall, and the body could be traced behind lying in the bottom of the Douglas's pouch. There was some leucorrhœal discharge, chiefly uterine, but not purulent-catarrhal. I at once gave my opinion against her marriage and introduced Meadows' compound stem, and recommended her to keep quiet for a few days. Her digestive system was fairly healthy, but she felt "out of sorts."

June 22nd.—Menstruation from 18th to 21st

without pain. Has a little discomfort "at the bottom of the stomach" on walking.

June 29th.—Experiences a sense of weight in hypogastrium on walking, more when lying down or sitting; occasionally sees a little "whites." Feels much better generally.

September 25th.—Last period three weeks ago, no pain; has "a little whites," and occasionally a slightly coloured discharge after the shaking of carriage. On examination, no leucorrhœa, instrument in normal position, no tenderness anywhere.

November 20th.—Feels very well, gets about "as if nothing the matter," general health "very much better than for a long time."

Removed the instrument and recommended her to use the hot douche diligently.

December 15th.—Menses from 7th "till 12th," no pain at the time, but for the last two days has had some discomfort in the right groin; the flow was very fair in amount and quality, uterus in very good position. Sound enters in normal direction, and without pain, slight leucorrhœa; strong pressure bimanually reveals, some tenderness in the region of the right ovary, but nothing can be felt. Bowels constipated, troublesome.

Prescribed a saline chalybeate aperient, recommended the continued use of douche, and gave it as my opinion that she might now get married.

March 19th, 1884.—Dr. Griffith informs me that he has just heard that the patient is in excellent

health and is pregnant, having been married a few months after last visit.

These two cases show that in this curious form of displacement we have a very reliable method of cure.

In a recent paper on the physiology and pathology of the *os uteri internum*, Dr. Henry Bennet * says, that, impressed by the "enthusiasm" of Simpson, he had, "for two or three years, divided the os uteri internum in nearly all the sterile women" he had met with, and the result was that "in the very great majority, indeed in nearly all, the sterility had persisted." As *a warning* against the indiscriminate use—amounting to serious abuse—of an excellent method, Dr. Bennet has done well to place such a practice and its results on record. I shall have failed in one of my objects if I have failed to guard the reader against the indiscriminate application of any method of treatment I have recommended. Surely, Dr. Bennet does not believe that the uterus is the only organ whose abnormal or unhealthy condition is concerned in the production of sterility! Anyhow, we now know that the Fallopian tubes, as well as the ovaries, are frequently at fault; and, unfortunately, certain diseases of these organs, which are an effectual bar to impregnation, are very difficult of diagnosis. Hence, when I am asked if I can cure sterility, I reply, that I may probably be able to cure any existing disease of the uterus, but the cure of sterility is quite another thing. If the

* Trans. Obst. Soc. Lond., Vol. XXV. 1883.

sterility be dependent on the condition of the uterus, such as anteflexion with or without stricture of the internal os, then it may be curable—many such have been cured—but if dependent on disease of the ovaries or tubes, then it is incurable. Hence we should always give a very guarded answer to this question.

When there exists organic stricture of the internal os along with the flexion, then the stem pessary will not suffice, but we must have recourse to the operation of *Hysterotomy* or division of the cervix. In my judgment this is the only condition—*i.e.*, organic stricture—which *requires* the operation. As happened about forty years ago in the case of Bennet, so, I believe, even at the present time, this operation is done more frequently than the cases warrant; and if unsuccessful, and even fatal, results have been so frequently observed, then the operators have only themselves to blame. The operation, if carefully performed, is singularly devoid of danger.

There are various methods of performing it. 1st, Bilateral division by Simpson's Hysterotome. 2nd, Bilateral division by the double Hysterotomes of Routh and Greenhalgh. 3rd, Bilateral division, first of the external os and cervix by scissors, and second, of the internal os by Sims' blade. 4th, Division of the posterior lip (Sims). 5th, Section of the internal os only. Of these I prefer Simpson's original method as the best and safest. I object to the scissors, because too much of the cervix is divided, and to Sims' operation of dividing the pos-

terior lip because I cannot see that an operation which results in a lopsided condition is to be preferred to one that aims at maintaining the symmetry of the organ; while the double instruments cannot be relied on to cut equally as intended—on both sides.

The method I adopt both in the operation and after-treatment is illustrated by the following:—

Case XXVI.—*Acute anteflexion; constriction of internal os; dysmenorrhœa; sterility; "division of cervix." Cure of dysmenorrhœa and sterility.*

Mrs. S——, aged 30, married fourteen months without issue, consulted me on March 23rd, 1876. She stated that menstruation had always been regular, and usually continued for four to five days. For the first two or three years had no pain "worth speaking of;" she then began to suffer, occasionally rather severely. After a few years more the pain had increased considerably, and since her marriage it had become very severe. This pain, always of the same character, but varying in intensity, usually accompanied the first few hours of the flow, and passed into a feeling of soreness. It was felt for the most part in the hypogastrium and left groin: never in the back. During the flow there was usually increased frequency of micturition, most marked on the first day.

On examination I found some muco-purulent

discharge in the vagina, the os was open, with a glairy discharge issuing from it; great congestion of the cervix, uterus sharply anteflexed, so that I could not introduce the sound until I had pulled the uterus straight with the volsella; the sound then entered the uterine cavity with a jerk, causing severe pain—the usual menstrual pain—and some bleeding. On removing the volsella the punctures of the teeth bled freely, to more than an ounce. The uterine cavity measured $2\frac{3}{4}$ inches full. I applied carbolic acid to the cervical canal, and prescribed a saline chalybeate aperient.

March 30th.—There being still marked congestion of the cervix, practised depletion by puncture, followed by glycerine plug.

April 28th.—Menses from 8th to 12th—13th, rather less pain, little or no leucorrhœa; the same difficulty and pain in passing the sound. Depletion repeated; to continue aperient; recommended division of the cervix, as likely to effect a cure.

The result of this recommendation was that I did not see the patient again till *a year and a-half* had elapsed—viz., on September 13th, 1877, when she returned, complaining of general weakness and depression, and great bearing down: the dysmenorrhœa was somewhat better. On examination the congestion had pretty well disappeared, but there was the same anteflexion with constriction of the internal os, as indicated by the sound. I again advised the operation, and she readily consented.

October 11th.—The patient being placed in the

lithotomy position and the vagina distended by means of the duckbill (Sims') speculum, I first pulled down and steadied the cervix with the volsella; I then attempted to introduce the hysterotome, but failed until after I had kept the uterus straight, by means of the sound, for several minutes: on withdrawing the sound I rapidly introduced the hysterotome, and succeeded in passing the obstruction, when I divided the tissues, first on the left and then on the right, more deeply at the external than the internal os. After allowing a loss of two or three ounces of blood, I then introduced a strip of lint, saturated with iodised glycerine, through the internal os, one end reaching well nigh to the fundus and the other just appearing at the external os, and over the os and cervix I placed a large tampon saturated with glycerine.

October 25th.—Leaving the first dressing for forty-eight hours, the lint and tampon have been daily renewed till to-day. The canal is now quite patulous, and the uterus is fairly straight. Patient returns home to-morrow.

December 4th.—Menstruated from November 23rd to 27th, scarcely any pain, "very different from what I have been used to," flow free; a small amount of clear, glairy discharge from the os, no trace of pus, slight congestion of the cervix; applied carbolic acid to cervical canal.

October 1st, 1878.—Patient delivered this day of a fine female child after a labour of *six* hours.

March, 1884.—This lady has now had five or six children.

In this case the division of the cervix, together with the method I have now for some years adopted of keeping the canal open by the daily introduction of a strip of lint until the healing process has been completed, served at once to remove the constriction and the flexion. But such a complete result is not always obtained, as the next case shows.

Case XXVII.—*Acute Anteflexion with stricture of the internal os; dysmenorrhœa; epileptiform convulsions; division of cervix, followed by uterine stem. Cure.*

Mrs. K——, aged 26, tall and thin, consulted me on December 11th, 1878. She stated that she had been married three years but had never been pregnant. Menstruation began at 14, and continued regular till about 21, rather scanty, lasting for four days, and without much pain. After this the periods became too frequent, with an interval of only a fortnight, and the pain became more severe, chiefly occurring during the first few hours of the flow, sometimes so severe as to cause nausea and even vomiting and faintness, while the flow increased in quantity and duration. For the last five months the periods had been irregular at varying *intervals* of three to four weeks. The last period was from the 2nd to 8th inst., and she had "very severe" pain the first day. About two years ago

began to have "whites," usually most abundant just before the period. For the last twelve months has suffered from attacks of dull, aching pain in the left groin, lasting from a few minutes to half an hour. These attacks have occurred very irregularly, but have been most frequent about the time of menstruation; sometimes they have been characterized by partial loss of consciousness and violent struggling, while the convulsive attacks themselves have been preceded by the *globus hystericus*. One of these attacks—a very severe one—occurred four days before the last period, and she has had several slight ones since.

Examination.—Some leucorrheal discharge in the vagina; uterus sharply anteflexed, cervix soft, somewhat conical, os small, but sound entered easily and without pain, until in passing through the internal os with a jerk it caused sharp pain; some tenderness at the fundus; cavity $2\frac{3}{4}$ inches—full.

She states, moreover, that her general health has deteriorated; and she looks ill. Appetite bad and bowels constipated.

I recommended division of the cervix as the first step, and to this the patient and her husband at once assented.

January 30th, 1879.—Divided the cervix bilaterally, as in the preceding case.

February 9th.—The lint has been changed daily since the 1st inst., the wound is now nearly healed, as indicated by the character of the discharge: there has been no constitutional nor local irritation.

May 29th.—After the lint was discontinued the sound was passed once—on February 13th—and the patient then returned home. Has menstruated four times since the operation, and without pain or hysterical attack, till last time; then had a great deal of pain the first day; the flow lasted a week; the hysterical attack was very slight. General health much improved.

On examination no vaginal discharge; os contracted to normal size, sound enters readily, no extra pain on passing internal os, uterus still flexed. Introduced one of my own stems; prescribed Hunyadi every morning to obviate constipation.

June 12th.—A coloured discharge set in on the evening of the 29th ult. and continued till the 10th, slight for a few days, rather free about middle of this period; has had no nervous disturbance, nor local distress; is not now conscious of the presence of the instrument. No vaginal discharge now. Recommended the use of warm douche with ½oz. of glycerine.

August 9th.—Feeling very well; last period about a fortnight ago, for six days; "scarcely any pain compared with former times," what there was occurred chiefly on the first day, but was "very slight"; flow not too free; more natural than formerly; no hysteria.

October 29th.—General health very good, menstruation from 15th to 25th; a little discomfort on fourth day; flow normal in quantity though pro-

tracted ; no return of the hysteria, &c. Removed the instrument.

Two or three years afterwards I heard that there had been no return of the hysteria, nor of the dysmenorrhœa, but that, although she was in very good health, she had not become pregnant.

Here the simple stem could be used ; for there was a good cervix occupying its normal position ; the cure of the constriction did not cure the dysmenorrhœa, but the straightening of the uterus did. This shows the importance of the flexion.

Duncan and Bennet recommend that we should give the preference to the process of dilatation. That this method has rendered good service I know by my own experience ; but it fails in proportion to the severity of the stricture. The experience of Surgeons in the very analogous stricture of the male urethra might have prepared us of the present day for such a result, while actual experience of the method itself is positive in its teaching. Dr. Macintosh, to whom we owe the introduction of this method, published a series of twenty-seven cases, with twenty-four cures, and of these eleven had children subsequently. Of this method Simpson thus spoke in one of his Clinical Lectures.* " I have repeatedly followed out Dr. Macintosh's plan of treatment by means of bougies of daily increasing size, and sometimes with perfect success. But you will find, if you come to try it, that it is an irksome and tedious process, taking up a great deal of your time, and

* Clinical Lectures, Edited by Black, 1872, p. 249.

often causing very great pain to the patient. So much suffering do some patients experience from this daily distension and dilatation of the os and cervix, that they are content to bear their monthly pain rather than submit to the ordeal of such a frequent torture; and therefore I have been led at various times to try different methods of attaining the object in view, viz., dilatation of the contracted orifice." He goes on to describe the use of the stem in graduated sizes, and then adds: "But I very frequently found that when the dilatation was effected mechanically, and whether slowly by hand, or rapidly by sponge-tents, relapse of the stricture or contraction was very apt to occur after a time; just as so often happens after the treatment of bad stricture of the male urethra by merely dilating instruments."* My own experience confirms that of Simpson. I have been frequently disappointed with the transient results of dilatation, and but seldom gratified by permanent benefit, or by the occurrence of pregnancy in a hitherto sterile woman, and experience has taught me to distrust it entirely in cases of stricture. In these it is of great service *after* division, and sometimes is the necessary complement of that operation.

I have under my care, as I write, two cases that are very instructive. One is a young lady, aged twenty-six, the subject of acute anteflexion, who has suffered from dysmenorrhœa, gradually increasing since the age of seventeen. I thought the case a

* *Op. cit.* p. 251.

fair one for the process of dilatation, and moderate depletion. In three sittings the canal was dilated up to No. 12, with the result that the pain was decidedly diminished. Although the dilatation was kept up at monthly intervals the dysmenorrhœa gradually returned, and became as bad as ever. It was not a case for division, and I had no resource but to try the stem. The result has been the most marked relief of all her symptoms. While during the process of dilatation she never got rid of more or less discomfort and sometimes even pain in the hypogastrium and left groin, on the other hand since the introduction of the stem she has not only menstruated without any "pain to speak of at all," but she has no discomfort of any kind, and the flow is of the most healthy character. Of course the flexion was not altered by the dilatation. Another is a married lady, aged thirty-two, who is very anxious to have a family. When she came under my care she had already had the canal dilated, but the stricture had returned, and a No. 8 bougie met with much resistance at the internal os and drew blood, but after two or three sittings a No. 12 passed easily and without drawing blood. Yet the patient was always ailing. At last I felt obliged to try the effect of a stem, as the flexion persisted. Within a month the patient not only looked a very different woman, but declared that she had never felt better in her life; and this she attributed to the stem. She continues to wear it.

Although Routh, Wynn Williams, Goodell,

Olshausen and others speak of cases where pregnancy has occurred in spite of the stem, yet I hesitate to employ this instrument in married women, for I cannot but feel that its presence is incompatible with the exercise of marital rights. Still I have not often found any unwillingness to yield on this point for the sake of prospective good results; I have, however, deemed it preferable to divide the cervix in such cases rather than to recommend the stem.

That the operation of division yielded in the hands of Simpson excellent results in a large number of cases is not to be denied, but that it was too frequently performed by him and others—Bennet, for instance, as already quoted—goes without saying. This was perhaps inevitable in the early days of such an operation. But we have no such excuse now. In carefully selected cases I maintain that it is absolutely necessary—that is, with our present knowledge. In my opinion, it should be reserved for those cases in which there is a well marked stricture of the internal os—such a case, for instance, as that from which the constricted tent, represented in Fig. 13, was obtained. Even should the stricture return, as it will sometimes do—unless the patient become pregnant within a short time—the subsequent process of dilating will be very simple, and readily yield a permanent good result.

I take the opportunity here of again protesting against the practice of introducing a stem im-

mediately after the operation of division. I have seen very serious results from such a practice. Here is an instance in point, viz., that of a single woman, now about forty years of age, who, about fifteen years ago, on account of anteflexion with dysmenorrhœa, underwent this treatment. The immediate result was a serious inflammatory attack from which she barely recovered with her life. Some months afterwards she came under my care, and by means of careful dilatation, and the subsequent wearing of a stem for a very short time, under very adverse circumstances, was greatly relieved. I then lost sight of her, for many years, until a few months ago, when she returned. The relief, it appears, lasted for a year or two, and then the old symptoms came back. She had in the meantime undergone a great variety of medical treatment without any benefit, and, remembering the benefit she had formerly received, she then sought my aid. On examination I found the uterus very sharply anteflexed, with great—I may say extreme—induration of the cervix, and even the body. The only treatment of which her circumstances permitted was dilatation, in the hope of softening the hardened tissues, and relieving the dysmenorrhœa. So great was the constriction that a No. 6 bougie passed at first along the canal with great difficulty, great pain, and considerable bleeding, and as it traversed the internal os produced an attack of vomiting. Gradually the tissues softened and the canal became more patulous, so that a

No. 11 bougie could be passed without producing either bleeding or retching. It was very instructive to observe that however tightly the bougie might fit the external os she never complained of pain, but that as soon as it began to distend the internal os, then the pain and retching began—again to cease as soon as it was withdrawn into the cervical canal. Coincidently with the local improvement her general symptoms improved, and she now gives promise of a good result. I have never seen such marked induration in an unmarried nulliparous woman.

Instead of introducing the stem immediately after the operation I strongly recommend the strip of lint, saturated with iodised glycerine, as at once more efficacious for the purpose in view and less likely to set up irritation. Care should be taken to make the incisions towards the broad ligament—I have seen the uterus divided through into Douglas's pouch—and to such an extent that a No. 12 bougie can be easily passed through the internal os; then, after a little blood has been allowed to flow, the lint is introduced. This is prepared in the following way. Cut a strip of lint from $\frac{3}{4}$ of an inch to 1 inch wide and 5 inches long; fold it longitudinally in the middle, double it, then trim to a point about $\frac{1}{4}$ of an inch wide, when saturated with glycerine the blunt point of a tapering uterine probe will not pass through the two thicknesses of the tent, and it can be readily introduced. It must be passed up to the fundus, and the strip being now only $2\frac{1}{2}$ inches long

the other end will just be visible at the os externum. Over this a cotton-wool plug—also saturated with glycerine, and made in the form of a boy's leather sucker—is carefully placed. After forty-eight hours they are both removed, and fresh ones substituted daily for about a fortnight: and it will be found advantageous in introducing the lint to pass the bougie first, the cervix being steadied by the hook or volsella. For the first week the lint will be well retained, and will show more or less pus, but towards the end of the treatment—which usually lasts a fortnight—it will most frequently be found to come away with the tampon, and by the time the treatment is discontinued with scarcely a trace of pus—if any at all.

Formerly the practice was to apply perchloride of iron as a hæmostatic, either by means of a brush dipped in the solution, or a piece of lint charged with the glycerole of iron. But this iron is objectionable both on account of the irritation and horrible stench it produces. I have never had occasion to use any hæmostatic since adopting the method I have just described, while the glycerine acts as a depleting as well as an antiseptic agent, in which latter aspect it is aided by the iodine. At first the iodine is used freely, but as the case progresses it is more sparingly employed and is gradually omitted.

To sum up the treatment I would say, at an early stage use the sound, bougie or tent; at a later stage employ the intra-uterine stem, either simple or com-

pound, and when the dysmenorrhœa is very severe, and the flexion very acute, and there is evidence, from the physical signs, that there is constriction of the internal os, then have recourse to the operation of division of the cervix, followed by the intra-uterine stem, with the precautions which common sense and moderate experience will suggest.

In describing how the various forms of pessary are to be *used,* I have necessarily included some of the modes in which they may be *abused.* But it will perhaps be well to devote a few lines to this special aspect of the question.

That the great majority of our general practitioners are profoundly ignorant, not only of the mode of action of the Hodge's pessary but also of the manner of applying it, is a statement that, I fear, must go uncontradicted. This is a condition of things that reflects little credit on our Medical Schools, or perhaps not so much on them as on our examining bodies. That there are a few notable exceptions I am happy to believe, and although Gynæcology is not at present represented in the examining boards as it should be, there are yet indications that, along with its twin sister Obstetrics, it will ere long receive that recognition which its importance demands. Notwithstanding the ignorance which unhappily prevails, it yet appears that nearly every general practitioner thinks himself quite capable of correctly applying a pessary. Hence the numerous and extraordinary mistakes that come to one's knowledge. That the pessary should be too

small, or of improper shape, or that it should be applied in unsuitable cases, need not excite much surprise; but that it should be applied upside down as well as, at the same time, reversed indicates profound ignorance of the rudiments of the subject. Even this is a very common occurrence. A very convenient cloak for this ignorance is the Ring pessary, which, fortunately, can only be misapplied by being either too large or too small. I hope I have said enough to drive the last nail into the coffin of this instrument, which has nothing to recommend it but its simplicity of application; but which stands condemned by its inefficiency.

There is nothing so prolific of the abuse of the pessary, whether vaginal or intra-uterine, as error of diagnosis. I have frequently known the ring pessary inserted in cases in which there has been no displacement whatever, but rather catarrh of the uterus. A marked case of this kind recently came under my notice. Here, however, the mistake is only important in so far as it prevents the employment of the proper treatment. But it is very different in the case of the stem. A remarkable case of this kind was recently published by Mr. Lawson Tait,* namely, one in which he had removed the suppurating Fallopian tubes, and in which this suppuration was supposed to have had some connection with the use of a stem pessary. The case was referred to as showing one of the injurious effects of the stem, when it should rather have been re-

* Trans. Obst. Soc. of London, 1883, p. 236.

garded as an example of ignorant *abuse* of the instrument.

A singular abuse of the vaginal pessary recently came under my notice. On October 27, 1883, I was asked to meet a medical friend in consultation upon the case of a lady about 50 years of age. She had, as she thought, ceased to menstruate three or four years previously; but a year or two ago she again began to be unwell, and for the last six months had lost profusely. While residing at the seaside she called in a medical man, who, after examination, introduced a Hodge's pessary, this time upside down. On removing this, the uterus was found anteverted, the os was of normal size for a multipara, but the cervix and body felt enlarged. This was proved by the use of the sound, which also showed by the bleeding that there was something wrong. A sponge-tent cleared up the case by revealing the presence of a mucous polypus. I don't know how far the use of the pessary was here the cause of the anteversion; but that it aggravated, if it did not cause it, I have not the slightest doubt.

It is not advisable to introduce a vaginal pessary during the existence of active or chronic inflammatory action in the pelvis, either of the uterus itself or its annexa, or even simple excoriation of the os; and when the reader is once more invited to remember that this pessary is employed for the purpose of *retaining* the uterus in its position *after* it has been replaced, and not of *replacing* the organ, this precaution will commend itself to his judgment as self-

obvious. Of course, special care is to be observed in the case of the intra-uterine stem, and if dilatation be necessary it is advisable to wait at least 24 hours before introducing the stem. That such precautions should be necessary has actually been used as an argument against their use, than which nothing can be more fallacious.

The presence of a fibroid in any part of the uterus is another contra-indication to the use of the vaginal pessary, though it is not always observed even by gynæcologists of repute. Some two and a half years ago I removed a large fibroid tumour by enucleation *per vaginam* from a single woman aged 54. She had been under three distinguished gynæcologists and in two of our general Hospitals, and one of these gentlemen introduced a large ring pessary for the purpose, I suppose, of supporting the uterus. The chief result of this proceeding was the production of a very copious offensive muco-purulent discharge, which had to be got rid of before any operation could be thought of. In this case the tumour was already projecting through the os uteri and involved the anterior lip, and the pessary prevented the descent of the tumour, while common sense should have indicated an opposite mode of treatment. In all such cases, the presence of the fibroid is infinitely more important than any displacement that may exist. For my part I cannot conceive a case of this kind in which a pessary is not more likely to do harm than good.

The first essential, then, in the intelligent use of

the pessary, and for the avoidance of its abuse, is a correct diagnosis, and the second is an understanding of the principles of its action. Without these, nothing but confusion and probable injury can follow.

The subject of PROLAPSUS, whether of the uterus or anterior vaginal wall and bladder, or both, demands a few words. Premising that this condition is best remedied by some operation, and that the treatment by pessary can only have for its object the palliation of symptoms, I hold that much good can be obtained from an intelligent use of some form of pessary or support. The instrument most commonly used for this purpose is Zwanke's pessary, and I must own that in my opinion it does not deserve the severe censure that has been heaped upon it by some writers. A young married woman will find it the most convenient ; for she can remove it at night and replace it in the morning. It does not interfere with the exercise of marital rights, nor prevent the chance of pregnancy occurring. I have known of more than one who has become pregnant in this way, and by appropriate management during the lying-in has been cured of her prolapsus. Another very useful instrument is Thomas's large, short S-shaped pessary. But where the cystocele is very marked, the bladder comes down between the two limbs of the instrument, and if it be not expelled, it at least causes much discomfort. In several cases in which, for various reasons, an operation was not feasible, I have filled in the anterior half of

the space between the longitudinal bars so as to present a flat surface to the bladder, and with the best result. Such an instrument I have recently adapted in the case of a lady—a widow—of very nervous temperament, who would not for a moment entertain the idea of an operation. I first applied an instrument of block tin, and having obtained the proper size and shape, I had one constructed in Vulcanite from this model. She expresses the most complete comfort from this instrument.

It will have been observed that the use of the HOT DOUCHE has been frequently referred to as an important element in the treatment under discussion, and there can be no doubt that it is of great service, not only as an agent of cleanliness, but also as a remedial measure. For the purpose of cleanliness it is not necessary to use a large quantity of water, but for the purpose of reducing congestion it must be used very freely, to the extent of two or three gallons, or, reckoned by time, for a period of from ten to twenty minutes. For the former, the Higginson's syringe answers the purpose very well, but for the latter, some other apparatus is necessary. Those most in use are, a metal or india-rubber receptacle hanging against the wall; Playfair's can, with a short tube let into the bottom and fitted with a tap; and the apparatus which Messrs. Krohne and Sesemann have constructed for me: see fig. 18.

The first is inconvenient from its small size, and the consequent necessity for its frequent filling. The second is very convenient and easy to use, but

has this great disadvantage that it cannot be carried about. The third is not only simple in its use, but

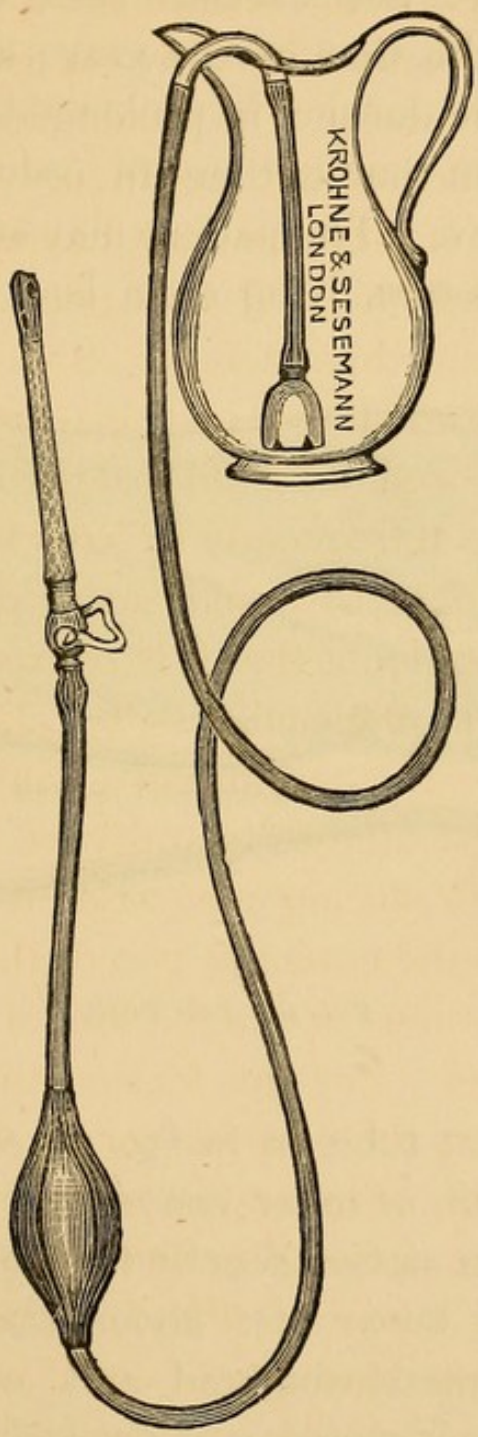


FIG. 18.—BANTOCK'S VAGINAL SIPHON-DOUCHE.

is also very easy of transport, admitting of being carried in a handbag or of being stowed away in a trunk. Every house possesses a bedroom ewer, or

common pail, and in most a water-can is to be found. The temperature of the water should not be below 105° F. nor exceed 120°, and will vary according to the time of the year; and it is necessary, when the douche is prolonged, to add some hot water from time to time in order to keep up the temperature. The patient may adopt either the recumbent posture, lying on a bed bath provided

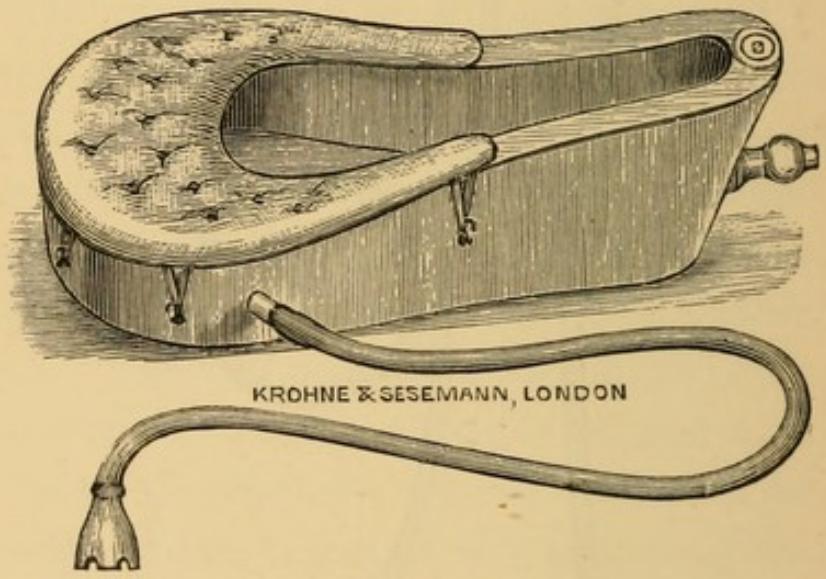


FIG. 19.—BED BATH.

with an efferent tube, as in fig. 19, or may sit on a bidet, foot bath, or other convenient receptacle.

In using the siphon-douche the jug, pail or can is placed about three feet above the level of the patient, the metal-weighted end is put into the water, the tap is closed, and the ball is compressed two or three times. In this way the air is expelled, and the tube is filled with water, and on opening the tap it will be found to run in a continuous shower. The tap is now shut, and the vaginal tube being

adjusted, the apparatus is ready for use. The difference between the comfort of this apparatus, and the discomfort and inconvenience of any pumping arrangement, scarcely admits of expression, and as it can be carried in a small handbag it is easy for the patient to carry it with her from home.

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