On the diagnosis and treatment of retroversion of the unimpregnated uterus / by J.Y. Simpson.

ON

THE DIAGNOSIS AND TREATMENT

OF

RETROVERSION

OF

THE UNIMPREGNATED UTERUS.

BY

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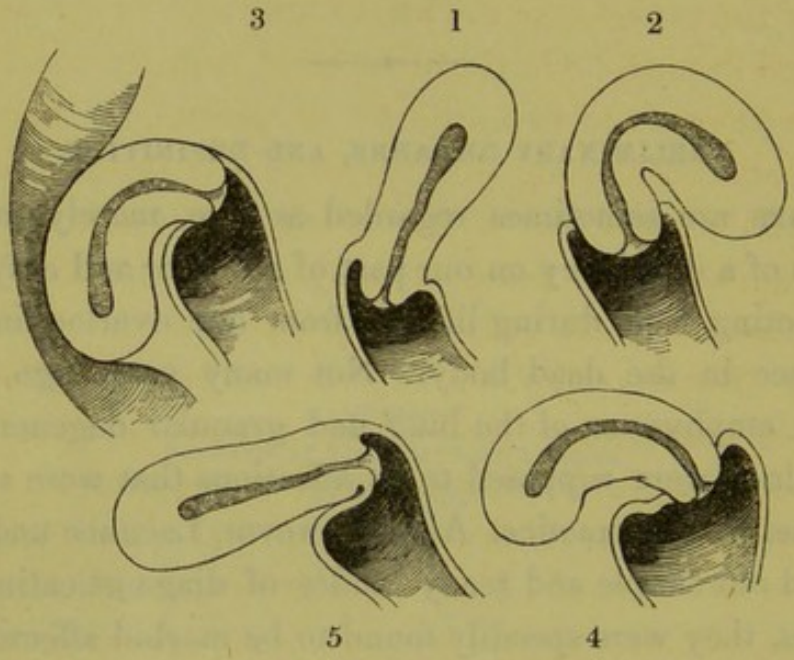
PRELIMINARY REMARKS, AND DEFINITION.

Diseases are sometimes regarded as rare, merely in consequence of a deficiency on our part of a proper and easy means of detecting them during life, or from our overlooking their existence in the dead body. Not many years ago, for instance, emphysema of the lung and granular degeneration of the kidney were supposed to be affections that were very seldom met with in practice. After, however, Laennec and Bright pointed out simple and ready modes of diagnosticating these diseases, they were speedily found to be morbid affections that were extremely common, instead of extremely rare, in their occurrence; and every physician at the present day is now ready to acknowledge their great frequency.

With some of the displacements of the unimpregnated uterus practitioners have long been familiar. In particular, the displacements of the organ downwards, in the form of prolapsus and procidentia, are recognised and acknowledged by all, and elaborately described in every work on female diseases. But displacements of the unimpregnated uterus, in the form of versions or flexions, either of the whole or of the upper part of the uterus, posteriorly, anteriorly, or laterally, have hitherto been looked upon as rare; and this, far more however, from our past want of power of diagnosticating them, than from their own infrequency.

In the present communication, it is my object to describe, briefly, some new and simple means that I have practised for the last four or five years for detecting and treating these displacements.

Let me premise that, in the normal and healthy state, the long axis of the uterus is situated in a line parallel with the line of the axis of the brim of the pelvis, or in the relative direction represented in the accompanying diagram (Fig. 1) (*a*). But the fundus of the uterus, instead of looking upwards, may



be turned downwards and forwards, or downwards and backwards. In Fig. 2 it is represented as directed downwards and forwards, constituting *antiversion*. In Figs. 3, 4, and 5, it is directed downwards and backwards, constituting *retroversion*. These three figures of retroversion (Figs. 3, 4, and 5) represent different forms or degrees of this displacement. The diagram, Fig. 3, represents an aggravated degree of retroversion, taken from a drawing of a case of this displacement by Frank. The mode in which the rectum is impressed by the retroverted uterus is shown in the diagram. He found this instance of

(*a*) These diagrams are intended to represent vertical or antero-posterior sections of the uterus, and upper part of the vagina. In fig. 1 the uterus is supposed to be placed in its normal position, and the other four figures represent different deviations of the organ from this position.

displacement of it in the body of a patient who had died of chest disease, but he does not give her previous history(*a*).

Some authors have attempted to draw a specific line of distinction between the forms of posterior displacement of the uterus pourtrayed in Figs. 4 and 5, and have described the form given in Fig. 4 as *retroflexion*, and that given in Fig. 5 as *retroversion*. In other words, by retroversion, properly so called, they would understand a displacement backwards of the entire organ (Fig. 5), the flexion taking place in the upper part of the vagina, and the uterus itself not being necessarily changed in form. On the other hand, retroflexion (Fig. 4) is a term proposed to designate the displacement backwards of the fundus only, along with more or less of the body of the uterus; the lower part of the cervix uteri retaining, in some degree, its natural position, and the flexion taking place in the substance of the body, or upper part of the cervix of the organ. But in reality, in the living subject, we meet with all possible intermediate shades and degrees of these posterior displacements; and I believe it to be an incorrect and unnecessary refinement to draw such theoretical nosological distinctions between them. Practically and pathologically, there is no true difference between these modifications or degrees of this morbid position of the uterus; and I shall in my subsequent remarks include them, and all other varieties of posterior displacement, under the generic term of Retroversion. Farther, in order to avoid repetition, I shall in the present communication treat only of retroversion of the uterus. It will be found that the same principles of diagnosis and treatment apply, *mutatis mutandis*, to the almost equally common displacement of the uterus which I have defined above as Antiversion.

ALLEGED RARITY OF RETROVERSION OF THE UNIMPREGNATED UTERUS.

In all our English systematic books on midwifery and

(*a*) *Opuscula Posthuma*, p. 78.

female diseases, down to the very latest works, retroversion of the *unimpregnated* uterus is described as an exceedingly rare disease.

In his work on the Diseases peculiar to Women (1846), Dr. Ashwell tells us that he has "been long in the habit of observing uterine organic disease;" but he states "the published cases of retroversion are nearly silent on any other cause than pregnancy;" and he speaks of this as the result also of his own observations(*a*).

Dr. Burns (1844) says: "Mr. Pearson relates a case where the uterus was retroverted in consequence of being scirrhous. Dr. Marcet gives an instance where the uterus was retroverted without pregnancy, producing constipation and vomiting. Dr. Alken (of Bergheim), relates a case where a woman, after suffering from difficulty of passing the urine and stools, had in fourteen days complete retention of both. The bladder reached to the umbilicus; the extremities were cold, the pulse small, vomiting, &c.: the urine was drawn off. After bleeding and the warm bath, force was employed in opposite directions, both from the rectum and vagina, and in an hour the uterus was replaced. It was, however, displaced again next day, but was reduced, and the retroversion did not return. The uterus was unimpregnated." Dr. Burns himself quotes these cases in illustration of his own opinion, that retroversion, besides occurring during pregnancy, "*may* also be produced when the womb is *enlarged* to a certain degree by disease."(*b*)

Writing in 1844, Dr. Churchill observes: "I have known retroversion to happen the first day of a menstrual period, when the weight of the uterus was increased by afflux of blood. Mr. Pearson and Dr. Blundell met with cases of retroversion caused by scirrhus. Callisen and Blundell mention cases where this accident followed delivery, *but such must be exceedingly rare.*"(*c*)

(*a*) Practical Treatise on the Diseases peculiar to Women, p. 598.

(*b*) Principles of Midwifery, p. 288.

(*c*) On the Principal Diseases of Females, p. 267.

The experience of the few last years has amply convinced me that these opinions regarding the supposed rarity of retroversion of the unimpregnated uterus are entirely wrong. Since discovering an easy method of detecting its existence, I have found it one of the most common and frequent displacements and affections of the unimpregnated uterus(*a*). My observations, in this respect, have been fully confirmed by several of my professional brethren in Edinburgh. Three or four years ago I pointed out its frequency, mode of diagnosis, and treatment, to my friends, Drs. Rigby and Protheroe Smith, of London; and I have much pleasure in adding, that their extensive opportunities at the London Hospital for Uterine Diseases have enabled them and the pupils of that useful institution to confirm amply the justness of my previous deductions, with regard to the great frequency of retroversion, and the advantages of my proposed methods of detecting and treating it.

SYMPTOMS AND DIAGNOSIS OF RETROVERSION.

General Remarks.—The morbid conditions of the uterus are recognized in practice by two classes of symptoms, viz., the *functional and physical.* The evidence derived from these two different classes is different in its nature and value.

All accoucheurs will, I believe, readily admit that the two following observations hold good with regard to the symptoms and diagnosis of utero-gestation, viz.:—1, That the state of the uterus in pregnancy (one and identical as it is) is liable to be accompanied, in different women, or in the same woman in different pregnancies, with very different local, sympathetic, and general effects or functional symptoms; and, 2, that the usual concourse and succession of functional phenomena, to which pregnancy generally gives rise, may be induced by other states and irritations of the organ than utero-gestation.

(*a*) In April, 1843, I stated these results in a communication to the Medico-Chirurgical Society of Edinburgh; showed the frequency of retroversion of the unimpregnated uterus, and its means of detection and cure. See Monthly Journal of Medical Science for 1843, p. 660.

The same two important inferences are true in regard to the various individual morbid affections of the uterus. The marked uncertainty which exists respecting the local and constitutional effects produced by the condition of the organ in *pregnancy*, holds equally good regarding the effects produced by it in its different states of actual *disease*. In uterine disease, as in pregnancy, the same specific affection of the organ excites sometimes very different phenomena in different cases; and the same specific phenomena frequently result from affections of the organ that are entirely at variance with each other in their pathological character, in their course, and in the treatment required.

In deciding upon the existence or non-existence of pregnancy, especially in any case of importance or doubt, no medical man, who valued his own professional character, would deem himself justified in offering a final and decisive opinion from the study of the mere functional symptoms only; nor would he venture to form a definite judgment, until he had made a sufficiently accurate local or *physical* examination of the state of the uterus itself In deciding, in the same way, upon the pathological nature, and consequently upon the line of treatment which any marked uterine disease may require, we believe exactly the same caution to be necessary, and the same local or physical examination to be demanded, where there exists any doubt, and where the examination is not otherwise counter-indicated. It is, assuredly, only by doing so that we can hope, with any certainty, to decide upon the *specific* nature of the uterine disease that may be present. We may make the general diagnosis of the existence of uterine disease by the consideration of the *functional* derangements to which such diseases give rise. We can only make the differential diagnosis of what the specific disease of the uterus really is, by aiding this by the physical examination of the structural condition of the organ itself. The study of the rational or functional symptoms may show that the organ is affected, without showing us how it is affected. They point out

the fact of the uterus being the seat of some diseased state or action, without pointing out what is the specific nature of that diseased state or action. To gain this last most important information, we must have recourse to the study of the physical signs or symptoms of uterine disease, in addition to the functional. In other words, we must attempt to ascertain the actual physical or structural condition of the uterus by the tactile and visual examination of the affected organ itself. We must endeavour to decipher and read its morbid anatomy on the living body, by the careful employment of the senses of touch and sight. Hence, then, I attach far less importance to the functional symptoms of retroversion which I have first to enumerate, than to the physical signs, which I shall afterwards consider.

FUNCTIONAL SYMPTOMS OR DERANGEMENTS.

In some cases of retroversion of the unimpregnated uterus (more especially when the displacement is chronic and the pelvis large), as in some other forms of serious uterine disease and of pregnancy, few or no marked functional or sympathetic symptoms, either local or general, are present; while in other instances the attendant functional derangements and irritations are excessively severe and distressing. And in this, as in other uterine affections, between these two extremes we may meet with every shade of difference.

In retroversion, as in other morbid conditions and diseases of the unimpregnated uterus, the accompanying sympathetic derangements or symptoms are, when they are well and highly marked, more or less perfect imitations of the secondary phenomena of pregnancy. Dyspeptic and hysterical symptoms are sometimes present, with local neuralgic pains in the mammæ; in some portions of the vertebral column; or, what is still more frequent, in the parietes of the abdomen or chest, and more especially in a limited spot beneath the left mamma. The displaced position of the uterus often gives rise to mechanical irritations and symptoms of the same kind as if the organ were

actually morbidly enlarged. Constipation and impeded defæcation are frequent results, partly from the fundus of the displaced uterus physically compressing the caliber of the rectum, and partly from its producing a functional inability to expel the feculent contents of the bowel through the lowest part of the canal. Occasionally the bowel is irritated, and there are discharged from it, from time to time, quantities of mucous or fibrinous-like effusions. The bladder frequently suffers from dysuria or retention; and, much more rarely, I have seen a degree of incontinence, especially where the urine has become phosphatic, from the want of power in some cases of completely emptying the bladder. Symptoms of weight, tension, and bearing down in the regions of the uterus and rectum, with dragging at the loins and in the regions of the uterine ligaments, are very common. Pains often stretch down one or both of the lower extremities. Occasionally there is an inability to bear carriage exercise, and walking and standing speedily produce fatigue. In a few rare cases I have known the patients to find themselves forced to remain almost constantly in the horizontal position, from the intense and overpowering feeling of pressure and malaise which the erect posture always brought on, and the power of standing and progression restored by the spontaneous or artificial reposition of the uterus. In general, all the symptoms, local and constitutional, which I have alluded to, are aggravated more or less by exercise in the erect position; and they are more particularly liable to be increased in their intensity when the uterus becomes periodically congested and heavier, at the recurrence of each menstrual period.

In some cases of retroversion the menstrual function is not morbidly altered. In other cases, however, I have seen the catamenial discharge affected, but affected most oppositely and variously,—occasionally in the way of amenorrhœa, sometimes of dysmenorrhœa, and not unfrequently of menorrhagia, particularly after miscarriage.

The mucous secretion of the uterus is not altered by re-

troversion, unless congestion or inflammation supervene; it may then change into leucorrhœa. Occasionally there is a sudden temporary increase of discharge, once or oftener during the intervals between the catamenial periods, as if it had collected in the cavity of the retroverted organ, and escaped, or become expelled, only from time to time.

When a patient with a retroverted uterus becomes pregnant, abortion is apt to take place. But I have seen various instances in which the uterus became spontaneously rectified in position as it became larger, and utero-gestation went on to the full time. Usually the existence of retroversion interferes with the function of conception. Often it is a cause of sterility, as shown by impregnation taking place after the displacement is rectified. In women who have borne children at distances of several years between each, I have several times found the uterus permanently retroverted in the unimpregnated state.

The functional symptoms that I have enumerated may make us suspect the existence of retroversion of the uterus. But retroversion may be present without most, or almost any of them; and they may be present with other diseases besides retroversion. Hence the necessity here, as elsewhere,—in this, as in other uterine affections,—of having recourse to the physical examination of the uterus, in order to decide and determine its actual morbid state.

PHYSICAL SIGNS OF RETROVERSION.

The usual physical means of diagnosis of uterine disease are reducible to the observation of phenomena by the senses of sight and touch.(*a*)

(*a*) In a few cases the sense of hearing is also had recourse to. I have repeatedly heard with the stethoscope a sound like the placental souffle in large fibrous tumours of the uterus. The uterine walls around these tumours are sometimes hypertrophied and thickened exactly like the walls of the uterus in pregnancy, and their vascular structure undergoes a similar increase and mutation. Hence, probably, the origin of the sound in question. When present, I believe it to serve, among others, as a diagnostic mark between fibrous tumours of the uterus and ovarian tumours.

Speculum.—The employment of sight, by means of the speculum, assists us in no respect in the diagnosis of retroversion.

Tactile Examination.—On an accurate vaginal examination we feel an apparent projection of a solid tumour between the uterus and rectum, when applying our finger, or fingers, behind the cervix uteri to the *posterior* part of the upper reflexion, or roof of the vagina. (At *a*, Plate I. fig. 1.) The same firm mass is felt through the anterior wall of the bowel in making an anal examination. The tumour or mass feels smooth and roundish on its surface; is often sensitive on pressure, more especially if the retroversion is recent, or when the posterior wall is (as often happens) congested and engorged; is generally capable of being moved more or less easily by the finger; and varies in size according to the degree of displacement, and the morbid or healthy state of the uterine walls.

The os and cervix uteri may be displaced forwards, or they may maintain their usual position. The whole body of the uterus is often prolapsed and lower than its natural situation; but occasionally it is quite normal in these respects.

How are we to determine that the solid tumour lying upon the back part of the roof of the vagina, and between the rectum and uterus, is the displaced fundus and body of the uterus?

If the patient be unusually thin and emaciated, and we examine simultaneously with one or two fingers of the right hand placed in the vagina, and those of the left hand placed above the pubis, we can almost feel the uterus between the two hands, and ascertain the whole position and relations of the organ; but this, however, can very rarely be accomplished.

Generally, we have by tactile examination no other means of knowing the probability of the apparent tumour being formed by the displaced fundus and body of the uterus, than by tracing along with the finger, between the tumour and cervix uteri, a direct *continuity* of structure, and this may be done either *per vaginam* or *per rectum*. But this physical sign is in

itself apt to lead into error, if alone depended on. If the uterus is retroflected more than retroverted, the continuity cannot be traced at the point or angle of flexion; while, on the other hand, a fibrous or other tumour attached to the back wall of the uterus sometimes may be distinctly traced to be *in continuity* with the uterine structure, and moves with all motions imparted to the cervix. Nor is the position of the os uteri any more certain guide, for sometimes it is not displaced when the fundus is so; and it may be thrown forwards by a tumour, when the fundus retains its normal position.

Other and additional means, therefore, of diagnosis become necessary. M. Pereyra, of Bordeaux, suggested, a few years ago, to attempt to obtain a more correct physical diagnosis for retroversion, by conducting the examination by the rectum or bladder. "The difficulty" (he observes) "of distinguishing diseased growths from retroversion of the uterus is greater than might at first be supposed; the only way of attaining a correct diagnosis is to ascertain if the uterus be or not in its normal situation. Two methods are proposed for this end; either the forefinger is introduced into the rectum, or a male catheter into the bladder, by the extremity of which instrument an exploratory process is conducted. The latter mode, treated of by Malgaigne(*a*), requires, of course, some tact, but to the experienced surgeon it will give the more certain indication."(*b*)

The determination of the case by an examination *per rectum* is impossible; and I have elsewhere shown that Malgaigne's method of diagnosis is attended with difficulties and uncertainties that render it quite useless in practice(*c*).

A far more simple and certain method is to determine the precise situation of the fundus and body of the uterus, not through either the intestinal canal behind, or the urinary canal in front, but through the intermediate genital canal itself. The

(*a*) *These du Concours*, 1833.

(*b*) American Journal of Medical Sciences, April, 1843, p. 483.

(*c*) See Monthly Journal of Medical Science for 1844, p. 214.

proper canal of the uterus is, of course, too narrow to allow us to introduce our finger into it; but by passing into it a slender metallic finger (if we so speak), we can easily by it ascertain, amongst other matters, any change in the *direction* of its cavity, and consequently in the direction of the body and fundus of the uterus itself. The employment of the uterine bougie readily enables us to do this.

Examination by the Uterine Sound or Bougie.—The form, &c., of the uterine bougie is represented in Plate I., and consequently requires little or no description. Some years ago I gave a full account of the instrument, and the mode of using it(*a*). It has the configuration of a slender male cathether; tapering in form; knobbed at the extremity; divided into sections, so as to measure, when required, the length of the uterine cavity; and provided with a handle, smooth on its posterior surface and roughened on its anterior (that surface represented in the Plate), in order to make the operator constantly aware of the position and direction of the point and concavity of the instrument, when it is passed into and hid in the uterine cavity(*b*).

(*a*) See Monthly Journal of Medical Science for 1843, p. 703, &c.

(*b*) The normal length of the cavity of the healthy uterus is two and a half inches, and at that point the bougie is marked, as seen in the figure, by a single elevation or knob, which can be readily felt when the instrument is under use, and at once advertises the practitioner that it is introduced the full length of the uterus. When the uterus is hypertrophied,—when enlarged with fibrous tumours, &c., &c.,—the cavity is elongated, and the degree of its elongation can be easily measured by the bougie. There are two elevations upon it, at four and a half inches from the point, in order to enable the physician to take his measurements easily without withdrawing it. Elsewhere than at two and a half and four and a half inches from the point there are depressions or grooves at inch distances for the same purpose. In cases in which the uterine cavity is diminished in length by inversion, &c., the bougie equally enables us to ascertain that point. The whole length of the stem is nine inches. It is represented in the plate as bent in the angled form in which I generally use it; but, being made of silver, its bend can be readily changed, increased, or diminished, to suit different cases and indications of use.

This instrument can be easily and readily passed into the uterine cavity, so as to enable us to measure its depth; to examine, more distinctly than we have otherwise the power of doing, its fundus, body, and cervix; to ascertain the presence of strictures in the canal; diseased states of the cavity, and walls of the organ, &c. I have used it daily for five or six years past, and have never, in any instance, seen any serious irritation, or any bad result to the uterus, follow its employment; whilst it has enabled me and others to detect and discriminate morbid conditions of this organ, that were, by any other means, entirely beyond the reach of correct diagnosis.

Its power of detecting retroversion of the unimpregnated uterus depends, as I have already stated, upon its directly and easily enabling us to ascertain the *direction of the uterine cavity*, and hence of the body and fundus of the uterus, which form the walls of that cavity.

When the uterus is in its normal position, and is placed with the long axis of the organ, and consequently the long axis of its cavity, in a line parallel with the axis of the pelvic brim, the point of the bougie, when introduced into the uterus, passes upwards and forwards in the direction of the umbilicus; and the concavity of the instrument (or the rough side of its handle) is directed towards the symphisis pubis. When, however, the uterus is retroverted, the point of the instrument, instead of passing up vertically and forwards, is resisted in that direction, and can only be passed horizontally and backwards towards the hollow of the sacrum; its concavity and the rough side of its handle thus looking towards the sacrum instead of towards the pubis, and at once showing the altered position of the cavity, body, and fundus of the uterus.

But the diagnosis may be made out still more completely and accurately by the further use of the bougie. For,—

1. Besides showing in the manner stated, the direction of the uterine cavity, and hence of the body and fundus of the uterus, by the direction in which the instrument itself passes,—

2. We can ascertain by a vaginal or anal examination of the supposed tumour, that the extremity of the uterine bougie is lodged in *its* centre, showing the swelling to be produced merely by the displaced fundus of the uterus; and,—

3. After this, by turning the bougie gently round so as to bring the concavity, or the rough side of its handle, to look to the pubis, instead of looking, as at first, to the sacrum, we can replace the uterus and feel it upon the bougie if required, through the abdominal parietes in front. We can thus certify to our own minds that we have nothing on the point of the instrument except the fundus uteri. And again, if necessary, by introducing a finger into the rectum or vagina, and then retroverting or replacing the uterus at will, we can as it were make and unmake, as often as required, the apparent tumour lying between the uterus and rectum, and thus further prove this tumour to be nothing whatever but the retroverted fundus uteri.

DIFFERENTIAL DIAGNOSIS OF RETROVERSION.

I have seen retroversion of the unimpregnated uterus not only very frequently and entirely overlooked, but also very often mistaken for other morbid states and lesions of the uterus. I shall point out the principal morbid conditions with which I have known it to be confounded, and the modes of distinguishing retroversion from them.

1. *From Pregnancy.*—In a considerable number of instances I have had occasion to see the feeling of fulness and apparent increased size of the uterus in retroversion mistaken for the earlier periods of utero-gestation. A few weeks ago I was called to a case at a distance from Edinburgh, where this error of diagnosis had led to much distress: from an unmarried lady, suffering severely from dysmenorrhœa and menorrhagia, being supposed by her medical attendant to be pregnant and aborting, from his mistaking the retroverted fundus and body of the uterus for general enlargement of the organ. This error

is still more liable to be committed when the retroversion is accompanied, as it sometimes is, with occasional amenorrhœa. Two or three years ago, I had under my care a patient with retroversion of the uterus and temporary amenorrhœa, who had been pronounced as undoubtedly pregnant, by her usual medical attendant, an excellent practitioner and lecturer on midwifery in another medical school. About the same time I had a patient under my own care with retroversion, who passed three successive menstrual periods; but I was certain, from no corresponding increase in the size of the retroverted uterus, that she was not pregnant. In this case the difficulty of the diagnosis was rendered the greater in consequence of the areolæ becoming darker and their follicles enlarged as in pregnancy. A drawing was made of the areolæ at the time; and afterwards, when the uterus was replaced, and the patient at last became pregnant, the areolæ were most certainly not deeper marked at the same period in the true, than what they had been in the spurious pregnancy.

2. *From Fibrous and other Tumours in the posterior Wall, &c., of the Uterus.*—This is one of the most frequent errors of diagnosis which I have met with, and one into which, in former times, I myself frequently fell.

The attendant functional symptoms are in all respects the same; and on examination there is the same continuity of structure felt between the cervix uteri and the body lying between it and the rectum. In this way retroversion of the uterus has very often been mistaken for a morbid growth upon the back part of the uterus, and even described as such(*a*).

(*a*) Dr. Hamilton, in his Outlines of Midwifery, describes retroversion as an "unequal projection" on the posterior part of the uterus. I have seen one or two patients whom he had pronounced in writing to be labouring under these "projections," and where the apparent tumour was the retroverted fundus uteri. In the work quoted he observes: "An unequal projection of different sizes is occasionally discovered on the posterior part of the uterus, resembling in shape the tubera which form upon the surface

But the introduction and direction of the uterine bougie at once enables us to solve the difficulty. The bougie passes backwards into the very body and centre of the apparent tumour, at once showing it to be the retroverted fundus uteri. It may be proper, however, to add, that instances are by no means rare in practice of the presence of small fibrous tumours attached to the posterior wall of the uterus being conjoined with retroversion.

I have known the retroverted fundus uteri to be pronounced a carcinomatous tumour, local thickening of the back walls, &c. The differential diagnosis is readily made, in the way I have just mentioned. When it has occurred after delivery I have seen it mistaken for the common puerperal hypertrophy of the uterus. The means of differential diagnosis are the same. And cases, in which the apparent swelling formed by the back wall of the deflected uterus have been (out of the pregnant and puerperal states) mistaken for simple general hypertrophy of the uterus, and assiduously treated by mercury, iodine, &c. &c., have frequently come under my notice.

3. *From Ovarian Tumours in their earlier Stages.*—When

of the liver, but differing from tubera in being of a more resisting texture, and in being pained on pressure. From the cases which have fallen under the author's notice, it appears to him that the following is the progress of this fortunately rare disease. At first there is a slight enlargement of the uterus, with a little thickening and tenderness of its posterior surface, occasioning a sense of bearing down on making any unusual exertion, and an obscure gnawing pain towards the back part of the pelvis. In the progress of the disease the posterior surface of the uterus becomes more and more unequal, till at last a distinct projection like a walnut, or even larger, can be felt on examination *per anum*. At this stage of the disease the patient can neither stand nor sit upright, such is the continued uneasiness in the back part of the pelvis. It is remarkable that in this, as well as in several other of the local diseases of the uterus, the catamenia continue to flow as usual. In the early stages of this disease the progress has been generally checked by the means employed in cases of chronic enlargement of the uterus; but in the latter stages, that is, after the circumscribed projection has taken place, no other means of treatment have hitherto proved successful."—*Outlines of Midwifery*, p. 134.

the ovary enlarges from multilocular degeneration, or other causes, it almost always first grows downwards into the space lying between the back wall of the uterus and the anterior part of the rectum, resting thus upon the roof of the vagina behind. In its enlargement it almost invariably pushes the uterus anteriorly, and *before* it; and this relative position of the uterus to ovarian tumours is often an important matter in the diagnosis of ovarian disease in its later and more advanced stages. At first the body of the enlarged ovary may be mistaken for the retroverted fundus uteri, more especially as the os uteri is generally displaced forwards. But the introduction of the bougie shows the uterus to be in its normal situation, and at the same time generally enables us to draw the uterus so far forwards as to make us certain that it is not attached to the existing tumour, and does not form one continuous structure with it. So far the evidence is merely negative. If further evidence of a positive kind, of the nature of the tumour, is required, we may obtain it by the use of a fine exploring needle, a means of diagnosis of great value in this as in other complications.

4. *From Pelvic Cellulitis.*—Inflammation of the cellular tissue of the pelvis, limited or more diffuse, is certainly a frequent disease, both after delivery and in the unimpregnated state. I have seen it now at many different periods of life, from six years up to sixty. It is generally spoken of as "pelvic abscess," but improperly so, for it does not always necessarily terminate in abscess, any more than pleurisy necessarily terminates in empyema. When the inflammatory effusion seems limited, as it sometimes is, to the space between the uterus and rectum, the firm tumour, or swelling formed by it, may be mistaken for retroversion. The direction of the bougie, when introduced into the uterus, will show us, however, that the uterus is *not* retroverted; and the accompanying symptoms, and, if necessary, the use of the exploring needle, will enable us to complete the diagnosis.

5. *From Extra-uterine Conceptions lodged between the Uterus and Rectum.*—Nauche, in his *Maladies des Femmes* (p. 108), mentions a case in which an extra-uterine conception was mistaken for a retroverted uterus. I lately met with an instance where it was a matter at first of great doubt and difficulty, whether the tumour lying on the anterior wall of the rectum, and accompanied with sudden symptoms of rupture into the peritonæum, was an enlarged and retroverted uterus, or an extra-uterine conception. Examinations with the bougie at once showed the uterus to be both normal in its size and in its position.

6. *From Organic Disease in the Anterior Wall of the Rectum.*—In a case of Dr. Marnoch's, the tactile examination of a tumour lying between the uterus and rectum gave me the idea that it was a retroverted uterus. The employment of the bougie, however, showed the uterus to be normally placed. On more minutely examining *per anum*, the anterior wall of the rectum was found much thickened and indurated; the patient died some months subsequently of carcinomatous stricture and disease of the rectum.

7. *From Stricture of the Rectum.*—The diagram of retroversion in Plate I. shows how readily this disease may be mistaken for stricture of the rectum; the deflected fundus uteri pressing in upon, and sometimes diminishing greatly, the caliber of the bowel. But the use of the bougie always readily dispels the difficulty, by showing first the direction of the fundus, and secondly (when the instrument is turned round), by at once removing the fundus and the supposed stricture. But I know that the mistake of confounding a retroverted uterus with stricture of the rectum is by no means infrequent in practice. Sir Charles Bell states that he had found a surgeon employing rectum bougies for years, on account of an obstruction from displaced uterus(*a*). A case of retroversion of the

(*a*) Institutes of Surgery, vol. ii. p. 216.

unimpregnated uterus some time ago came under the care of a medical friend of mine in Edinburgh. He discovered the displacement, introduced the wire pessary (third form), which I shall afterwards describe, and at once rendered his patient comfortable, and capable of taking exercise. She returned to her own distant home, with a line to her physician, who declared he knew the instrument well, but thought it necessary to take it out at the menstrual period, and could not again replace it. Another distinguished obstetrician was called in his place. He said the uterus was enlarged, and not displaced; used leeches, &c. Not finding the desired benefit from this treatment, the lady placed herself under the care of an eminent surgeon, who pronounced all the previous opinions wrong, and that the real disease was stricture of the rectum. The last time I heard of the patient she was submitting to the frequent use of bougies for the cure of this imaginary affection.

RETROVERSION LIABLE TO ESCAPE NOTICE EVEN IN POST MORTEM EXAMINATIONS.

In the preceding pages I have spoken of retroversion of the unimpregnated uterus being with extreme frequency entirely mistaken in practice, and overlooked during life. But even after death the same error is liable to occur. In the Edinburgh Medical and Surgical Journal for 1822, Dr. Robertson details (page 525) a case most illustrative of this remark. A woman died of tenesmus, constipation, and symptoms of obstructed bowel, ending in enteritis. Before death the rectum was examined for the obstruction, and the gut was found "encroached on by a tumour which, *per vaginam*, was discovered to be the uterus." "But," adds Dr. R., "on the *post mortem* examination, to our surprise, no uterine *tumour* was found to encroach on the rectum." In this, as in other cases in which retroversion of the uterus has existed, the morbid displacement has, on the inspection of the body after death, escaped notice, from the form and structure, and not the mere

position, of the uterus being looked to. In our common *post mortem* method of examining the pelvic contents from above, the attention of the morbid anatomist is rarely or never directed to the observation of any mere deflection of the fundus and body of the uterus; and when once the parts are dragged out of their situation, it is impossible to ascertain the amount and degree of retroversion.

ORGANIC STATE OF THE UTERUS IN RETROVERSION.

This is very variable. I have seen it several times co-existing with the presence of fibrous tumours in the uterine parietes. More frequently the uterus is hypertrophied merely from chronic metritis, and the enlargement more especially marked in the posterior walls. The organ is at the same time elongated as well as hypertrophied; and its cavity, instead of measuring two and a half inches in length, will measure three or three and a half inches. Many authors seem to think that enlargement of the uterus, under some form or another, is a necessary preliminary to retroversion taking place, and that we never meet with the displacement without finding it combined with some increase in the size of the organ. Such, however, is assuredly not the fact. In a large proportion of cases the retroverted uterus is in no degree enlarged or increased in volume, but natural in size. Nay, I have on more than one occasion seen the uterus retroverted when it was less than normal in its length and dimensions. Latterly I have happened to be consulted in several instances of amenorrhœa in women advanced beyond twenty or thirty years of life, in whom the menstrual secretion had never appeared, and where, on examination, the uterus was found imperfectly developed, and the length of its cavity, as measured by the uterine bougie, was not above one, one and a half, or at most two inches. In one of these instances, in which the cavity of the uterus was only one and a half inches long, the fundus of the preternaturally small organ was, at the same time, distinctly retroverted,

and felt like a small roundish tumour through the vagina and rectum. Some time ago I saw, with my friend Dr. Girdwood, of Paddington, a case still more rare. The uterus was retroverted, as he had ascertained by examination and the use of the bougie. There was a second orifice in the cervix uteri. On introducing a second bougie into this additional orifice, I found it pass into a second uterine cavity, quite separated and distinct from the first, and with the fundus of each diverging from the other. In fact, the uterus was not only retroverted, but double. It is, as far as I am aware, the first case in which a double uterus has been distinctly diagnosticated upon the living subject.

TREATMENT OF RETROVERSION OF THE UNIMPREGNATED UTERUS.

When recent, and occurring after some straining effort, or from congestion and inflammation of the uterus, or subsequent to delivery, mere replacement of the organ by the bougie or finger will sometimes suffice, provided, along with it, we enforce for a length of time the horizontal position, or rather lying on the side or face, prevent over-distension of the rectum and bladder, reduce any local congestive or inflammatory state that may be present, and restore the local tone of the relaxed soft structures of the pelvis by astringent vaginal injections, or by the use of medicated pessaries made with ointment containing extract of oak-bark, or tannin, or iodide of lead, &c.

But such simple treatment rarely succeeds, even when the retroversion is recent; and still more seldom when, as is almost always the case in practice, the displacement is already chronic and confirmed. Under these circumstances we have three principal indications to perform :—1. To remove, if necessary and possible, any morbid action in the uterine structures that may exist along with the displacement. 2. To restore the uterus to its normal situation. 3. To use means to retain it

in its replaced and natural position. I shall speak separately of these several indications.

1. *Removal of any Morbid State of the Uterus that may co-exist with the Retroversion.*—Not unfrequently, along with retroversion, the uterus is congested and hypertrophied, and the uterine bougie shows it to be elongated half an inch or more. Sometimes chronic inflammation of the body of the organ is present, and more especially in its posterior wall, which often feels tumefied and tender to the touch: or the cervix is enlarged, condensed, and ulcerated, especially in its posterior lip. The os uteri, or the uterine canal, an inch or so above the os, is not unfrequently contracted and strictured, and may have been giving rise to retention of the menses and congestion. Occasionally one or both ovaries can be felt through the roof of the vagina, enlarged and painful from congestive or inflammatory irritation. As a general rule, all these morbid states should, when possible, be reduced and removed, or at least moderated by their appropriate means of treatment, before engaging with the other indications to be fulfilled, particularly when they are apparently in any respect the *cause* of the retroversion. More frequently, however, they are the *effects* of the retroversion; and in this latter case our means of combating them will usually fail, or only partially succeed, till we have first restored the organ to its natural form and situation, by our fulfilling the second and third indications which I have laid down, before we fulfil the first. When the retroversion is combined with and produced by the presence of fibrous tumours in the posterior wall or fundus of the uterus, the first indication cannot, of course, be accomplished, as we as yet possess no certain power of removing and discussing these tumours.

2. *Restoration of the Uterus to its Normal Situation.*—Most authors who have treated of retroversion of the unimpregnated uterus have spoken as if its replacement could generally be fully effected by the fingers alone. In practice, however, its

complete replacement by this means is almost always found to be impossible. By pushing up the retroverted fundus, or by pulling down the cervix, or by combining simultaneously both measures, the replacement can sometimes be effected by the fingers alone; but rarely. For it is scarcely ever possible, by any pressure which we can make with the fingers upon the posterior surface of the uterus, either through the vagina or through the rectum, to push the fundus uteri upwards and forwards to a sufficient degree. Some authors, finding their fingers to fail, from their shortness, &c. have proposed instruments for the purpose. Richter and Evrat suggested a species of vectis or probang, to be used through the rectum. Bellanger, Lallemand, and Duges, have spoken of introducing a strong sound into the urethra and bladder, to act as a lever upon the os uteri. Siebold and Drejer attempted to replace the uterus by instruments made of whalebone, introduced into the vagina, and made to press by their upper and blunted extremities upon the fundus uteri through the upper and back portion of the vaginal parietes.

The simplest and most easy method of temporarily replacing the retroverted uterus is by introducing an instrument into the cavity of the organ itself, and using it as a mechanical means, or lever, for the purpose. In treating of the physical diagnosis of retroversion, I have shewn how the uterine bougie can be readily used for this purpose. The very means of diagnosis are thus, at the same time, the very means of replacement.

3. *Retention of the Replaced Uterus in its Normal Situation.*—This is necessary to effect a cure. Some, as Schmitt and Schweighœuser, have supposed that it could be accomplished by the mere position of the patient, and that lying on the side or face, with the pelvis somewhat elevated, would be sufficient. I have already stated that in few,—exceedingly few cases, indeed,—will it be found to succeed, and these only of recent origin. Instruments for the purpose of supporting and retain-

ing the uterus *in situ* are therefore necessary. They have been proposed to be worn in the rectum(*a*) and in the vagina(*b*). Various forms and modifications of vaginal pessaries have been invented by Hervez, Drejer, Sander, &c. They are all intended either to press principally, by guarded stems or otherwise, through the roof of the vagina, upon the tumour formed by the fundus uteri; or to keep the cervix uteri pushed back, with the view of throwing the fundus forwards. I have used sponges for this last purpose; and Siebold and Kilian state, that they believe they form the best pessaries for retroversion, modified according to the necessities of each case. Moreau conceives that the principle of treatment should be to fill up the space between the uterus and rectum, so as to take away any room for the retroversion to recur: he uses a kind of caoutchouc pessary for this purpose. Two years ago I removed from a patient one which had been worn for some months, and which Moreau himself had introduced. It had not in any degree benefited the retroversion.

After detecting the ease and certainty with which the uterine bougie could be used for the discovery of retroversion, and for the temporary restitution of the organ, it appeared to me that the most direct and perfect method of retaining the replaced uterus *in situ* would consist in some means of retaining and fixing, as it were, the end of the bougie for a time in the uterine cavity. I soon found that the restoration of the uterus temporarily, from day to day, with the bougie, was insufficient, and that some more permanent means of keeping the organ replaced and retained were necessary But one primary and important point required to be solved:—Would the uterus bear with impunity the presence of such a body for a length of time in its own cavity? My first experiment on the subject I made with extreme anxiety, and great misgivings as to the results. I watched the case from hour to hour, and from day

(*a*) Ætius, Vernandois, Desault. (*b*) Colombat, Dugês, &c.

to day, and was delighted to find that the presence of the instrument was borne by the uterus without irritation or annoyance. The patient was almost entirely incapacitated from walking, by retroversion of the uterus, before it was used. After thus wearing for some months a wire pessary in the cavity of the uterus, she so far recovered as to bear two children, one in this country, and subsequently another in India. I soon found, in other cases, that, when the instrument was once properly fitted and adjusted, it could be borne with perfect safety, and without any pain or inconvenience. Occasionally I have since met with cases in which the uterine pessary has created so much irritation as to render its withdrawal necessary in a few days after it was introduced. But these cases have been exceptions, and by no means common or frequent exceptions, to the general rule; and I have allowed the instrument sometimes to remain in the uterus for two, four, six months, or longer. Within the last few weeks I have removed two uterine pessaries, one of which I had introduced eight, and the other nearly ten months previously. They are not to be interfered with at the menstrual periods. Sometimes, though by no means always, a slight menorrhagia follows their use, particularly for the first period or two after their introduction.

It is unnecessary to detail the changes of form which were tried, and the difficulties I met with, in first attempting to construct a proper uterine pessary. The three forms which I have been in the habit of using for the last three or four years are those depicted in Plate II.(*a*)

First form of Uterine Pessary, Plate II. fig. 4.—The stem of the instrument (2⅓ inches long) (d) is introduced into the uterine cavity; the lips of the cervix uteri rest upon the flattened ovoid bulb or ball. Fig. 5 shows the lower surface of

(*a*) Mr. Young, our cutler in Edinburgh, makes them of German silver; sometimes he has electrotyped them for me but this addition is unnecessary.

the bulb or ball, with an orifice in it to allow of the end (a) of a handle (fig. 6), about 8 inches in length, to be fixed in it, for facilitating its introduction into the uterus. This form of pessary generally answers much better for antiversion than for retroversion. Occasionally I have had the bulb made of lead, that it might serve as a counterpoise to hold the os uteri *in situ*. The instrument, however, is imperfect, from the impossibility usually of retaining it in the uterus above a few days, the canal relaxing and dilating, and allowing of its escape. In fact it is exactly the form of bougie which I generally use to dilate the os and canal of the uterus in cases of stricture, in any cases in which I do not employ the knife or hysterotome for that purpose.

Second Form of Pessary, fig. 3,—Has a similar uterine stem and bulb, and in addition a large ovoid disc, $2\frac{5}{8}$ inches in length, $1\frac{1}{4}$ inch broad, and $\frac{1}{2}$ an inch in depth, to retain the instrument *in situ*. The bulb (b) for the cervix uteri to rest upon is fixed in the middle of the disc, and the uterine stem (c) is moveable to a certain extent upon it. This is necessary in consequence of the size of the retaining disc, and the impossibility of introducing the instrument into the uterus and genital passages, with the stem fixed upright, and at right angles to the plane of the disc. The dotted line (d) represents the stem laid down, as is required in the introduction and withdrawal of the instrument. On the lower surface of the instrument (which is not seen in the figure) there is a spring-catch to hold the stem fixed and upright after the instrument is introduced, and capable of being unlocked by the nail when the instrument requires to be again withdrawn. The expanded disc, by pressing on the sides of the vagina, enables the uterine portion of the pessary to keep its situation. In some cases this instrument answers well in retaining the replaced uterus. But occasionally, when the *tendency* to displacement is *great*, this form of pessary is altogether inadequate, and will be moved about by the changes of position which the uterus itself undergoes. The

remaining form which I most frequently employ is free from these disadvantages. The two first forms are, when used, altogether concealed within the genital passages. In this third form a portion of the instrument is placed externally, and another internally.

Third Form of Pessary.—It is made up of two parts:—1. *An internal part* (fig. 2), provided, like the two preceding pessaries, with a stem (f), to pass into the uterine cavity; a bulb or ball (e), for the cervix to rest upon; and, in addition, a vaginal portion, or curvilinear tube (d). 2. *An external part* (fig. 1), consisting of a wire frame-work (a, c, s), to maintain and hold the internal portion *in situ*. This external part, or wire frame, is about five inches long; at its lowest or vaginal portion it is about ½ an inch broad; and towards its upper, or pubic portion, it suddenly swells out to 3 inches in breadth. From the vaginal extremity of this frame projects, at nearly right angles to it, a flat tubular portion (s) 2½ inches long, closed at its further extremity, like the point of a female catheter, and fitted to slide into and fix in the corresponding open tube (*a*) attached to the bulb of the internal half of the instrument(*b*).

In the Plate the uterine stem of the instrument is represented as placed in the cavity (h) of the uterus, a section of the organ (f) being outlined around it. In introducing the instrument, the internal portion, fig. 2, is first passed into the uterus and vagina, in the same way as the uterine bougie is passed

(*a*) I have a patient at present wearing one of these pessaries with a stem three and a half inches long. The retroverted uterus is enlarged and elongated by fibrous tumours in its walls, and one of the ordinary pessaries did not suffice to hold it replaced.

(*b*) The different parts of the pessaries in figures 1, 2, and 3, are represented as somewhat below their actual size, in order to suit the size of the plate. The bulb or ball is, in general, made an inch and half long, one inch broad, and about half an inch thick. I have sometimes used a larger bulb. When smaller it is apt to produce dilatation of the os uteri, and even to pass partially into it.

[The accompanying plates were kindly furnished by Dr. Simpson.—Ed.]

for the purpose of diagnosis. The retroverted uterus is then replaced by raising it up upon this portion of the instrument, which is turned round for that purpose. After the organ is replaced, the solid vaginal portion attached to the external frame of the pessary is slid into the corresponding vaginal tube (d) of the internal half of the instrument, locking into it on the same principle as the stilet locks into the canula of a curved trocar. Thus the instrument is, as it were, rendered at once completely solid and fixed. In order to have room to lock the two portions together, it is necessary, in general, first to bend back the pubic portion of the external frame-work to a very considerable extent, for the purpose of avoiding its being caught and impeded by the anterior part of the pelvis or pubis. After the locking is accomplished, this pubic portion of the instrument is bent, and moulded upon the anterior portion of the pelvis, so as to fit it as exactly as possible. Formerly I was in the habit of attempting to keep the instrument more permanently fixed, by having elastic tapes fixed posteriorly into the apertures (c), and anteriorly into those still represented in the upper part of the pubic portion of the instrument; and both attached to a band encircling the trunk of the body. This arrangement I always now dispense with as unnecessary. If the pubic portion of the pessary is properly bent in over the pubis, it generally takes a sufficient hold; and if ought more is found necessary, all that is required, in addition, is, that the patient wear a common napkin, or understrap, to pass between the limbs and over the instrument. Latterly I have had the instrument made without the part (c) projecting posteriorly.

It is, perhaps, almost unnecessary to add that, if the instrument is found to press disagreeably on any part, it may be easily bent without removing it, so as to take off that pressure; and it may thus require to be modelled and adjusted again and again in various parts, it order that it may be ultimately worn without annoyance and inconvenience.

When required to be withdrawn, the pubic portion is first

bent back, so as to be clear of the pubis; then the vaginal pieces are unlocked; and, lastly, the internal part is extracted.

The time during which it requires to be worn, in order to effect a cure, varies in different cases from one or two weeks to many months. The recent or chronic character of the case, and particularly the degree of tendency to the recurrence of the retroversion, are our principal guides on this head.

The employment of these uterine pessaries will cure many, but by no means all cases of retroversion of the unimpregnated uterus. And even when not sufficient to cure, they will generally relieve the patient, and palliate her annoyances and sufferings.

If the retroversion were causing no unpleasant symptoms, nor interfering with the functions of the uterus, I have always recommended the avoidance instead of the adoption of local measures and remedies, either mechanical or others. When the reverse was the case, I have employed the means I have mentioned, with the effect of curing many and of relieving others. In the few exceptional cases in which no pessary could be borne, in consequence of the irritable state of the uterus, or where they failed to produce a cure, I have contented myself with reducing this morbid state of the parts by leeching, external counter-irritation, the application of belladonna ointment pessaries, &c., and rest, in the first instance, followed afterwards by the employment of local and general tonic measures. The patient often derives much relief from wearing an abdominal bandage (as those of Hamilton and Hull), with a supporting perinæal pad.

I have not entered into the consideration of the *Causes* of retroversion of the unimpregnated uterus. An explanation of these causes, and, indeed, of uterine displacement in general, is only to be found, I believe, in a complete study of the forms, relations, and functions of the different parts and layers of the

pelvic fascia. In retroversion, those portions of this fascia which unite the back part of the uterus to the rectum and pelvic cavity behind, partially yield and give way. To re-strengthen this support, and allow of its renovation, retention of the uterus for a length of time in the position and mode I have described, often suffices. The simultaneous use of local injections and baths aid further the same view. But I allude here to the subject principally to observe that we may yet find further means of strengthening the weakened tissues, by indurating and contracting the upper and posterior portion of the vagina, as by the use of caustics, thus taking advantage of that contracting and strengthening power of the new tissue of cicatrices which burned surfaces particularly have. I think I have seen the application of nitric acid and potassa to the posterior lip of the uterus, produce replacement.

BIBLIOGRAPHICAL NOTE.

In the fifth century Ætius treated definitely and at length of retroversion of the unimpregnated uterus (*Tetrabiblos*, sermo iv. cap. 77); Moschion has left us some notices of it (*Spachius' Gynæcia*, p. 24); and in his work on female diseases, Roderick a Castro has some observations upon it (*De Universa Muliebrium Morborum Medicina*, p. 274). In modern medical literature, the first individual case of retroversion of the unimpregnated uterus that was put upon record was reported by Saxtorph, in 1775 (*Collectanea Hauvniensia*, vol. ii. p. 129). In 1779 Willich described a second case (*Richter's Bibliothek*, vol. v.). In 1786, in a woman who died of pulmonary disease, Peter Frank found the uterus greatly retroverted, and published a notice and drawing of the displacement (*Opuscula Posthuma*, p. 78). In 1787, Jahn noticed its occasional occurrence in the unimpregnated uterus, but considered it "too obscure and too unimportant to deserve the name of a disease" (*Dissertatio de Utero Retroflexo*, in Schlegel's *Sylloge Operum Minorum Præstantiorum ad Artem Obstetricam*, &c., p. 612). A few years subsequently, Schneider (*Richter's Bibliothek*, vol. xi.) and Kirschner (*Stark's Archives*, vol. iv.) published each a case of this affection. In 1817 Schweighauser of Strasbourg pointed out that retroversion of the unimpregnated uterus was far from being rare, and he asserted it to occur much more frequently than in the gravid uterus (*Aufsätze uber einige Physiologische und Prahtische Gegenstande der Geburtshülfe*). In 1820, Schmitt published at

Vienna an essay taking the same view (*Uber die Zurückbeugung de Gebärmutter bei Nichtschwangeren*, &c.) Subsequently individual cases of retroversion of the unimpregnated uterus, or more general remarks regarding it, have been published by D'Outrepont (*Zeitschrift für Geburtskunde*, 1827), Denman (*Introduction to the Practice of Midwifery*, p. 138), Cooper (*Anatomy and Surgical Treatment of Abdominal Hernia*, part ii. p. 59, 1827), Robertson (*Edinburgh Medical and Surgical Journal*, 1822, vol. xviii. p. 520), Velpeau (*Traite de l'Art des Accouchemens*, vol. ii. p. 622), Bazin de Basseneville (*Memoire sur la Retroversion de l'Uterus*, 1837), Moreau (*Traité Pratique des Accouchemens*, vol. i. 1838), &c., &c. I have referred in a preceding page to the first observations which I published on the matter, in the Abstract of the Proceedings of the Medico-Chirurgical Society of Edinburgh. I shall extract these remarks from the Monthly Journal of Medical Science for July, 1843, p. 660: "As one of the most important of all these applications of the uterine bougie, Dr. Simpson demonstrated that, by showing the *direction* of the uterine cavity, and hence of the uterus itself, and by its enabling us, when it is introduced, to change at will the position of the organ, it afforded a simple means of detecting those displacements of the unimpregnated uterus known by the names of retroversion and retroflexion, antiversion and antiflexion,—states that Dr. Simpson further showed were *very common*, and which, from the want of proper means of diagnosis, had been almost constantly mistaken for fibrous, carcinomatous, and other tumours situated between the uterus and rectum, or between the uterus and bladder. In cases of retroflexion and antiflexion of the unimpregnated uterus, the organ can with facility be temporarily restored to its normal position and relations, by turning the uterine bougie, when used as a means of diagnosis. Dr. Simpson proposed to maintain and fix the bougie in the uterine cavity for a length of time as a means of cure. He laid before the Society a number of utero-vaginal pessaries, which had been used by him for this purpose. They were constructed of nickel and silver wire, and had each attached to them a part which passed up to the fundus uteri. Some of them had been worn for weeks and months in the uterine cavity, and had produced little or no irritation." In 1846, Dr. Rigby published some excellent and accurate observations on the disease (*Medical Times*, p. 292, &c.); and more lately Dr. Protheroe Smith has written on the subject (*Obstetric Record*, p. 35, &c.); see also Mr. Hensley (*Provincial Medical and Surgical Journal* for January, 1848); and Dr. Beatty (*Dublin Journal* for November, 1847); &c.

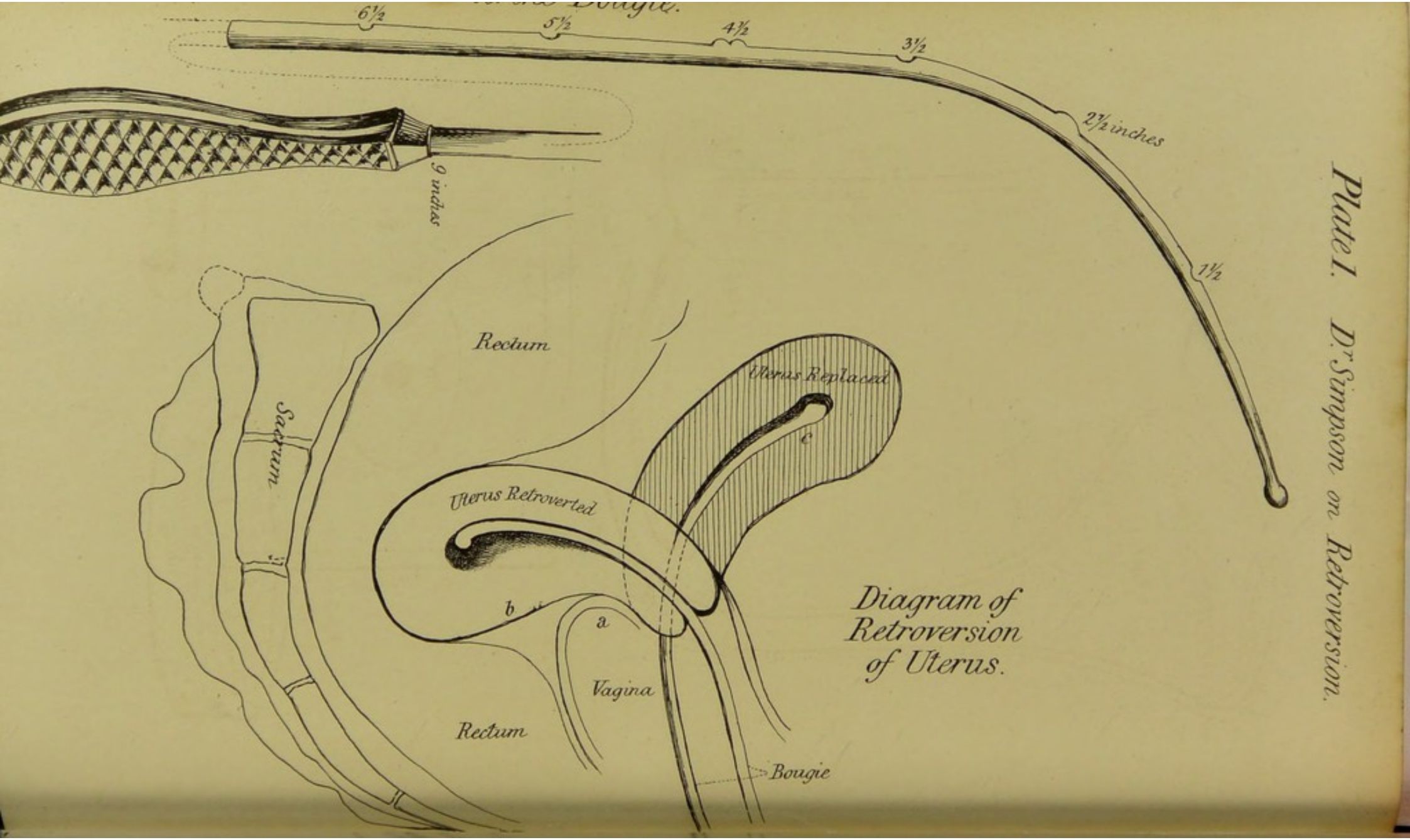


Diagram of Retroversion of Uterus.

Plate I. Dr. Simpson on Retroversion.

Plate II. Pessaries for Retroversion &c.