A report on laceration of the cervix uteri / by T. B. Harvey ; stenographically reported for the Indiana State Medical Society at Indianapolis, May, 1883.

A REPORT ON

Laceration of the Cervix Uteri,

BY

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LACERATION OF THE CERVIX UTERI.

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[Stenographically reported.]

MR. PRESIDENT AND GENTLEMEN—The subject of laceration of the cervix uteri has never, I believe, been reported upon or discussed in this Society. It is comparatively a new subject, of which nothing was definitely known until 1862, when Dr. T. A. Emmet, of New York, discovered what he regarded as laceration. The older members of the profession know that prior to that date we were in the habit of looking upon what is now regarded as laceration as inflammation, ulceration or hypertrophy, and for fifteen years we had been following the views and treatment of Henry Bennet, of London.

This was natural; Bennet had conferred a great favor on the profession by discovering as early as 1845 that certain diseases of the cervix which had been regarded by the French and English authorities as epithelioma, and for which amputation had been performed, were, in his opinion, simply inflammations, and so he removed these maladies from the domain of malignant diseases.

Those who have had experience in this matter, will remember the great reputation that amputation of the cervix once held as a cure for malignant disease. We now well know that genuine malignant disease of the uterus is generally fatal, and amputation only delays death, while prior to the discovery of Bennet, malignant disease was regarded as of frequent occurrence, and amputation was regarded as the proper treatment.

For years the profession followed the views of Bennet, treating such cases by cauterization, and it remained for Dr. Emmet, in 1862, to discover that what was regarded by Bennet as inflammation was really laceration, and that a little surgical

operation upon the cervix cured patients who, under Bennet's method of treatment, remained sick and debilitated for months and years, never in reality being cured, the disease returning when it was apparently destroyed.

The frequency of laceration of the cervix is much greater than is commonly supposed. Emmet claims that thirty-three per cent. of child-bearing women who suffer from uterine disease have laceration; Goodell one in six; my own observation leads me to think it occurs even oftener than Emmet supposes, as more cases of laceration are met with in my practice than of all other uterine diseases combined. I think its frequency is greatly underestimated rather than overestimated. But enough in regard to the history and frequency of laceration; these are matters of record and statistics, open to the student of gynecology and belong more properly to an extended and carefully written paper, than to an extempore discussion of this nature, like the present, which I desire to draw from my own observations and practice, rather than from the written histories and literature of the subject.

I will pass on to the causes of laceration; of these I have little to say, because of them little is known; the asserted causes are mainly guesswork.

Probably precipitate labor should be assigned as one of the causes; this may be spontaneous, or it may be the result of improper treatment, as the use of ergot before full dilatation; or of instruments necessary to save the life of mother or child, or both. Laceration may be produced by either the proper or improper use of forceps; the use of both forceps and ergot should be very carefully guarded. Laceration may also be caused by unfortunate and abnormal positions of the head, or of other parts.

I at one time thought laceration of the cervix more frequent on the left side than on the right, as the occiput is more frequently found in that position.

Stretching the os uteri with the fingers to facilitate labor may be a cause of laceration; such procedure certainly produces a good deal of irritation and congestion, and must precipitate labor before the parts are properly dilated.

So much for the causes; and now as to the results. These are immediate and remote, and in my judgment the former have not been properly estimated by the profession. Prominent among them are hemorrhage, uterine inflammations, and septicæmia. Sub-involution, impaired locomotion, displacements, and nervous disturbances may be classed among the remote effects.

As to hemorrhage, I have no doubt that many cases of post partem hemorrhage in which the blood is believed to come from the cavity of the uterus because of premature separation of the placenta, are really due to laceration of the cervix. I saw a case at a coroner's inquest in this city, in which the cervix was torn completely up to the junction of the body and cervix. I think the woman died from hemorrhage and septicæmia, although there was no evidence of hemorrhage from within the uterus; and, no doubt, many cases of slighter laceration occur and give rise to alarming hemorrhages, which could be controlled by local applications.

Inflammations of the uterus and its appendages are, as is well known, common occurrences. Following parturition we may have a fever; often there may be puerperal fever. Now what are the causes of puerperal fever? I do not propose, at this time, to discuss them, but will say that I believe laceration of the cervix, either slight or extensive, is probably among the most frequent causes. I am certain that in my own practice I have seen cases of puerperal fever resulting from this lesion. Septicæmia naturally follows laceration, from the absorption of poisonous matters through the open vessels.

The remote results of laceration of the cervix are what we have mostly to deal with, and first among them I place sub-involution of the uterus. I know the causes of sub-involution have never been satisfactorily explained. Some authors state that any inflammation about the uterus is liable to produce this difficulty. I think the point is well taken that sub-involution is very liable to be one of the remote results of laceration of the cervix.

Impaired locomotion is another remote result. There are few patients who suffer from extensive laceration of the cervix who do not also suffer from impaired locomotion, pain in walking, numbness, pain in sitting and rising, and a continual sensation of weariness in the back and in the lower extremities.

Sub-involution of the vagina as well as of the uterus is also to be regarded as a remote result of cervical laceration. Eversion of the cervical mucous membrane is, in the very nature of the case, one of the most common results of this affection. This eversion does not necessarily take place at first. Should you be called to see a patient a week or a month after the laceration, complaining, for example, of a constant pain—pain upon touch, pain upon motion; a pain which may well be compared to that resulting from a fissure of the anus—you might scarcely be willing to recognize or believe the fact that a slight laceration, a simple split in the cervix, is the real and primary cause of the difficulty. But such pains are, nevertheless, frequently the result of slight laceration of the cervix, and that, too, before hypertrophy and eversion have taken place. Eversion, although a common result of laceration, renders the case more difficult of diagnosis. This difficulty is particularly emphasized where there is a bilateral laceration. In such cases both sides become inverted and identified with the mucous membrane, and if the laceration extends the same distance up each lip of the cervix, the lips become equally enlarged, and there is presented what appears to be simply a large os, or cervix, and you may be led to treat the case *a la* Bennet, as a simple inflammation or ulceration of the cervix.

Granular and cystic degenerations of the cervix uteri are among the results of laceration.

Epithelioma is also to be added to the category, and I think that Emmet was right in his claim that laceration of the cervix is one of the most potent causes of epithelioma.

You will find in some cases of long standing and extensive laceration the little shot-like bodies, which are regarded by some authors as evidences of malignant disease. They are nothing more than little cysts filled to repletion, because of inflammation,

with their natural secretion. Break them down and the secretion escapes.

Suppose the case goes on for years and this fluid continues to accumulate; your patient may have vegetating epithelioma, in common parlance called cauliflower excresence, or ulcerating epithelioma.

Other troubles follow in the wake of laceration. I have found metrorrhagia, menorrhagia, dysmenorrhea and leucorrhea combined in one case. How can such an array of symptoms occur? Simply from the fact that there is a double laceration with stricture just above the point of bifurcation. The stricture produces dysmenorrhea, and this, in the course of time, is followed by menorrhagia, and in most of such cases there will be a little blood passing away during the entire month, constituting metrorrhagia.

In a case at the City Hospital, suffering with all the symptoms I have mentioned, and also with epilepsy, I found double laceration, and operated on both sides, and as a result the whole train of symptoms—dysmenorrhea, metrorrhagia, menorrhagia and leucorrhea, disappeared, and the epilepsy also, and the patient has suffered no return of them since. This case was a remarkable one on account of the great variety of symptoms present, particularly the epilepsy, and was witnessed throughout its course and to its successful termination by a class of over a hundred medical students and physicians. Up to within ten or fifteen years the conditions and symptoms following laceration were misunderstood; they were attributed to ulceration and inflammation, and the like. I was misled myself, with others, by Bennet as to the real nature of these cases.

I never saw a true case of lacerated cervix cured by the treatment advised by Bennet. Patients might be treated two or three months by his method, and then go away, only to return saying, "Doctor, I am as bad off as ever."

Bennet insisted that you must be very sure to cure your case before discharging it, otherwise it would return again. The fact is, he did not discover laceration, did not bring the parts together, and so did not cure his cases; of course each always returned complaining, "Doctor, you can not have arrived

at the facts; there is something that you do not understand yet, or you surely could have cured me." That was before Emmet, to the credit of the profession and the relief of suffering women, discovered laceration of the cervix.

Displacement of the uterus is a condition rarely absent in laceration, although a few cases occur in which displacement does not follow—unless we regard a simple sinking down in the pelvic cavity as a displacement, which it essentially is.

Retroversion is the most common form, and is more frequently the result of laceration than of all other causes combined. I make this assertion without any fear whatever of its being disproved by any physician who will carefully consider the subject.

As to the symptoms of laceration I have considered most of them in discussing the attendant results. There is one condition which may properly be called a result, although it is also a symptom; I refer to the great disturbance of the nervous system found in connection with laceration. I may say that I think there are in any given number of cases suffering with nervous disturbance due to uterine troubles, a greater number attributable to laceration of the cervix than from all other causes put together. I recall two cases of catalepsy—if I have ever met this disease in my practice—at least they were characterized by all the symptoms which are called cataleptic—that were perfectly cured by trachelorraphy. I also recall two cases of epilepsy cured in this way. Proofs can be given that they were cured by the operation. One case, which I regard as rather a remarkable one, suffered with great nervous disturbance, amenorrhea with ectopic, or, as it is more commonly but less properly called, vicarious menstruation. In this case a very good physician had made a diagnosis of consumption, on account of the recurring hemoptysis, with the prognosis that when the leaves put out in the spring the patient would die of the disease. This patient was perfectly cured of misplaced menstruation and all attendant evils by an operation for double laceration of the cervix.

Not only have patients been treated for consumption, but also for chronic cystitis, when the trouble was neither more nor less than irritation of the bladder, resulting from two causes:

one the reflex irritation from the disease which is in the cervix itself, the other the displacement of the uterus dragging the bladder out of place because of its attachment to the uterus by the vesico-uterine ligaments, producing painful and frequent micturition.

As to the application of caustics in cases of lacerated cervix, they will no doubt do the patient good for the time being. They make her think she is getting well; they also, which is the bad feature in the case, make the physician think he is curing his patient, when in fact he is only relieving her.

When I say this I wish also to add that for fifteen years I practiced according to the theory of Bennet, and I would be glad in the light of present knowledge to go back over my practice and ask permission to cure some patients that I then left uncured. I remember how they appeared and how I labored to cure them, and how anxious they were to follow my directions. I can see laceration in their cases now, but I treated them for a long time without knowing of the laceration. I state this experience to convince you that we have not fully appreciated this subject. Much has been said, and a great deal in derision, of this matter both at home and abroad.

It has been claimed that when a physician becomes a specialist, treating a certain run of diseases, he is as one whose eye has been long fixed on one color; the outer world loses its real appearance to shine only with unnatural tints. This may be true; such suggestions may be well enough to guard us, but I think that if the medical profession ignores this subject, if it fails to recognize that laceration exists frequently as a grave uterine disease, and one amenable to surgical treatment, it will do itself, alike with its patients, a great iujustice. Not only is the interest of the physician and patient involved in this matter but also the home itself, for miscarriage and premature labor are among the results of laceration of the cervix. We all have patients who have borne one child at full term and all of whose subsequent labors have been premature.

I have one patient in this city whose husband called on me two years ago with this history: "Doctor, my wife went to full term with her first child; she has had eight premature births

at the seventh or eighth month, and is now in great pain at her seventh month. Will you go and see her?" I found the os uteri dilated; I could feel the head of the fœtus through the dilatation; it was what I should have called, twenty years ago, an oblique position of the uterus, with the os pointing toward the left iliac fossa, when really it proved to be a bad case of unilateral cervical laceration. I at once put the patient to bed and under the influence of opiates, and by keeping her quiet in bed, succeeded in conducting the labor safely to full term. You will bear in mind in this connection that at the time of parturition diagnosis of cervical laceration had been made. I know Emmet claims that we should operate immediately after the labor in which the cervix is ruptured. I doubt, however, if any man can make a diagnosis immediately after laceration has occurred. The lips of the os are then flaccid, and the os is often found dilated; the internal os contracts immediately after the expulsion of the placenta, while the external os does not contract but remains soft; it flares out, and is not readily detected.

In the case just related, which by the use of rest and opiates, was enabled to go to full term, I reasoned as follows: Here is a case in which I have determined two months before labor the exact location of the laceration. I will examine carefully, after parturition, and see if I can then detect it. At the proper time I made the examination, and could only feel the cicatricial tissue at the point of bifurcation; the remaining portion of the os felt to the touch simply like the large soft os following parturition. I make these statements to convince you, as I am convinced myself, that the physician is not to blame for the occurrence of laceration unless he has wrongly given ergot or other oxytocics, or has instituted some treatment that should have been omitted. I emphasize the statement then that the physician is not necessarily to blame for the occurrence of laceration of the cervix, and should not be censured for not immediately detecting it after parturition, and at once putting it up.

I know there is a good degree of sensitiveness existing among all who have kept track of the recent history and liter-

ature of laceration, for fear that a patient for whom we have been the accoucheur may fall into the hands of a brother practitioner and be found on examination to be suffering from this affection. I hold that no physician who has done his full duty in an obstetric case is to be censured for having failed to diagnose laceration of the cervix uteri immediately on its occurrence.

The reverse is true in case of laceration of the perineum; the latter is an accident of labor which the intelligent physician can see immediately after, or even at the instant of its happening, and he should put it up at once. For many years I have done so in my practice, and that even within the hour of its occurrence, and with no other aid than that of the husband, who assisted in holding the parts with one hand, and held a tallow dip with the other.

I regret that I could not possibly be present last year, when a paper was read on laceration of the female perineum. If put together immediately after parturition, the parts will reunite and the perineum will be perfect before the patient leaves her bed. Failure will not occur in one case out of a hundred if the operation is timely and properly performed. I hold that it is the duty of the physician, instead of going off and saying "I never had a case of lacerated perineum occur in my practice," and instead of ignoring such cases and leaving women to suffer in after years for fear he may be censured for not having so conducted the labor as to prevent the laceration, to admit its presence, and explain that it is an accident of labor that may happen in the hands of the most skillful and experienced obstetrician.

Scanzoni states that he has prevented many cases from perineal laceration by making several incisions around the parts; probably, however, no obstetrician is sufficiently expert to prevent laceration, and our writers on gynecology and our teachers in medical colleges and societies, instead of teaching students and practitioners how they can always prevent laceration of the perineum, should say: "Gentlemen, you can not always prevent laceration of the perineum; it will happen in certain cases in

spite of all your efforts to prevent it; all that you can do is to give chloroform and allow plenty of time to relax the parts."

But when it does occur let us admit it, and explain to patient and friends that it is not an uncommon accident of labor; that the physician is always looking out for it, and is there to restore it, and that if properly and immediately treated, the patient will be well in a week. The physician who says that it will not heal by first intention, or that he don't get a good union upon immediate restoration, has either not put it up properly, or does not know what he is talking about.

I may say here, and in no spirit of boasting, but only to impress upon you the necessity of immediate operation for your own defense and the relief of suffering women, that I have had in a large practice in this line but two failures, and these are not to be properly regarded as failures; there was in each case a little fistulous opening, which was readily cured by the application of nitric acid.

But this is a digression from the subject, but one of such practical bearing, that I need make no excuse for its presentation. A few words as to the diagnosis of cervical laceration and I am done, for I do not desire to be tedious, and well know how tired you are at this late hour of the day. I may say that the diagnosis may in some cases be made by the sense of touch, and in other cases can not be so made; however, an intelligent diagnosis may generally be made by vaginal touch, but if the laceration be bilateral with eversion and hypertrophy, or if the apparently enlarged lips be uniformly everted, you may not be able to do so; your fingers in such cases will not indicate the point of laceration.

Then the speculum is to be brought into use, and you may discover an effort at cicatrization; you can see too, that the parts are red, that they are rolled out; in short, that there is both laceration and eversion. By taking a tenaculum in each hand, and attaching one to the anterior and the other to the posterior lip, you can draw the labia apart or draw them together so as to roll in the red hypertrophied tissue, and discover the extent of the laceration. I admit that there are some cases in which it is difficult to determine whether there is or is not laceration;

especially is this true in that form beginning at the os internum and extending down through the muscular tissue, tearing the internal mucous membrane and muscular structure of the cervix, but leaving the vaginal mucous membrane covering the cervix intact, thus obscuring all external appearance of rupture.

The parts look natural, except that the os is dilated; such cases remain so for years. This condition Emmet explains by comparing the muscular structures between the internal and external os to the ribs of an umbrella, the vaginal portion of the mucous membrane of the cervix answering to the covering.

As to treatment of laceration of the cervix, I have little to say. The patient is prepared for operation by frequent vaginal injections of hot water, by applications of iodine, and incisions of the mucous cysts, so as to reduce the hypertrophy of the parts; the edges of the lacerated lips are then pared, following closely the injunction of Emmet to remove all hypertrophied tissue, and then the lips are brought together with silver sutures. The operation is of course attended with some danger, but it is certainly less so than any other operation that does as much good.

In the operation the so-called "circular artery" of Sims and Emmet may be cut, especially in vivifying the angles of an extensive laceration. Owing to the natural elasticity of this artery it yields rather than ruptures when laceration does take place, and afterwards becomes covered with cicatricial tissue, but it still lies in close proximity to the surface, and is liable to be cut during the paring of the deep angle of the laceration. Emmet advises the use of the uterine tourniquet for prevention of hemorrhage in case this artery is cut; I have one of the instruments, but have not much faith in it on account of increased venous hemorrhage. And in case of profuse hemorrhage I at once pass a silver suture through the lips of the wound, and so close it and control the bleeding. I cut this artery last winter while operating without the use of an anæsthetic because of the opposition of the patient. She begged me not to use anæsthetics, but still she could not hold still because of the pain, and because of her movements I cut the circular artery. I shall not operate again

without the use of ether, and am surprised that any one is in the habit of operating without the use of anæsthetics. But I will not detain you with the details of the operative procedure; it is a simple plastic operation within the scope of any surgeon or physician of sufficient intelligence to diagnose the laceration, or appreciate the necessity and results of the operation. I will only say that more than a score of my students are in the habit of performing it whenever found necessary, and have by so doing brought credit to themselves as competent practitioners, and restored patients suffering endless pains and tortures to perfect health, and so have brought peace and comfort into what were otherwise shattered lives and homes.

After operation for laceration displacements of the uterus may require some attention. If there has been retroversion for a number of years, restoring the cervix alone will not bring the uterus to its normal position; a pessary may be required to support the uterus in place for perhaps three months, or even a year, or it may be until pregnancy occurs.

There are of course many related topics which from necessity I have omitted. But my object was not to discuss laceration of the cervix in all its relations and complications so much as to give you a few leading points from my own practice and experience in a plain and matter-of-fact conversational way, so that I might encourage you to give this department of uterine therapeutics the credit I so conscientiously believe it merits, and to encourage you to add this operation to your list for the relief of suffering women. You will find, if you do so, it will reward you pecuniarily and professionally, and in fact in all those honorable ways desirable to a physician. I know very well that I may be regarded as somewhat enthusiastic in this matter; I claim I have a right to be so. I have seen many patients cured so perfectly that the trouble never returned again.

The operation may be derided, but derision does not hurt truth. If a man is in the right he can bear all the derision that may be heaped upon him. Science, whether in or out of medicine, is not thus obstructed very long. Derision did not defeat Jenner, although his enemies claimed that the children vaccinated with the bovine virus would have horns growing out of their heads.

Atley went on operating for ovarian tumors when his eminent colleagues and the profession generally condemned the operation, even roughly saying, there could be no reason that justified a surgeon in "ripping up a woman's belly with the knife," and yet we now know well that ovariotomists have saved thousands of lives by the operation of McDowell.

Twenty-five years ago a woman with an ovarian tumor, was presented to a medical class, not to show the operation, but to show the tumor, although the operation had been successfully performed in 1809.

Such is the conservative feeling of the profession in regard to what seems to be an innovation. This spirit has actually prevented the progress of medical science by condemning certain views and procedures; this has been, also, the history of the operation for laceration of the cervix. Emmet has, I believe, modified his earlier views somewhat; if so, I think unjustly, for I believe that it is in the line he first indicated that we are to cure the majority of women who are suffering to-day with inflammation, so-called; of displacements, of leucorrhea, of dysmenorrhea, and, in fact, of the entire list of diseases, whatever their synonyms, that we have denominated as inflammation and ulceration.

In answer to the question, during the discussion, as to what cases to operate on? Dr. Harvey said:

I simply want to say in regard to drawing the line as to what cases to operate on, and what not to operate upon, that I think the objection is overdrawn. It is safe to say if there are no results from the laceration do not operate; but I don't think you ever can have a laceration of the os uteri that will not in time be followed by results. What is it that brings the patient to you if there are no results—if she is not suffering? If there is no laceration do not operate; if there is laceration, operate! It is a little like the use of forceps; I, as Prof. Reamy says, never use forceps until I get to the house.