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REPORT OF FIVE CASES OF UTERINE RETRODISPLACEMENT TREATED BY VAGINAL FIXATION (MACKENRODT).*

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During the last few years, differences of opinion have been so great as to the proper method of treating retrodisplacements of the uterus which give rise to symptoms, by operative measures, that reports of cases, especially those treated by the more recent procedures, are of interest, and will be useful in helping us to form an opinion as to the best method for relieving this, at times, annoying local trouble.

Vagino-fixation, followed by Curettage, Oophorectomy, and Appendicitis.—B. S., a married woman, twenty-seven years of age, was admitted to the gynæcological ward of the City Hospital, November 22, 1895. She stated that her first menstrual period occurred during her fifteenth year, that the menstrual flow was regular, of the tri-

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weekly type, and that it was preceded by pain located in the lower abdominal region. Eight years ago she had had a child, the labor being normal in all respects. Five months prior to admission, her last menstrual flow had occurred, and since that time she had suffered form metrorrhagia. Vaginal examination revealed an enlarged, hard, tender, and retroplaced uterus, accompanied by an enlarged and tender ovary on its right side. The case was diagnosticated as one of "chronic endometritis, retrodisplaced uterus, and small ovarian cyst." On December 2d, after the usual preparation of the patient, and under ether narcosis, she was re-examined vaginally, and as the right ovary felt smaller than when the previous examination was made, it was decided not to open the peritoneal cavity, but to perform curettage and vaginofixation of the uterus, after it had been anteverted, according to the method devised by Mackenrodt, of Berlin. These procedures having been carried out in the usual manner, excepting for the fact that no gauze was placed in the uterine cavity, the convalescence was uneventful, and the patient left the hospital with the uterus in good position on December 30th.

On January 5, 1896, the patient was re-admitted to the gynæcological service of the hospital, complaining of much pain in her right side. On January 13th, after the usual preparation of the patient, and under ether narcosis, the abdominal cavity was opened by an incision to the left of the median line, splitting the rectus muscles of that side and incising the other tissues. The uterus was found to be well anteverted and adherent. Several small cysts were found in the left ovary. These were excised, and the resulting wounds were sutured with fine silk. The right ovary contained a larger cyst, and as there appeared to be no normal ovarian tissue, it was removed after the peritoneal cavity had been freely irrigated with normal saline solution. The wound in the abdominal wall was closed by a single row of silkworm-gut sutures, which were passed through all the layers of tissue.

On January 22d the patient's bodily temperature rose to 103° F., and she complained of severe abdominal pain in her right inguinal region, radiating down her right thigh. Vaginal examination at this time proved negative. As the symptoms continued with unabated severity, on January 23d, under ether narcosis, the pelvic cavity was opened by an incision in the posterior vaginal wall, and the region explored with the finger. Palpation revealed the fact that there were no adhesions about the left ovary, but that high up on the right side some adhesions existed. Those within reach were broken up, but no pus escaped. After free irrigation, a piece of iodoform gauze was placed in the pelvic cavity for the purpose of effecting drainage should the abscess rupture in this direction. On January 24th, the vaginal packing and pelvic gauze were removed, but there was no discharge of a purulent character. The patient's temperature was 104°, and she complained of severe, lancinating pain in the right inguinal region. On January 25th, the patient's condition was unchanged. She was prepared and placed under ether narcosis, and the abdominal wall was incised. In this way a large abscess was reached and evacuated. It seemed probable that it was of appendical origin, as at the time of the oophorectomy the appendix was adherent, but as it did not appear to be much injured, on examination, it was not removed. The further convalescence was uneventful.

Lizzie S., a single woman, twenty-three years of age, was admitted to the gynæcological service at the City Hospital, January 22, 1896. She stated that her first menstrual period occurred during her thirteenth year; that it had been irregular and painful. She had had one child, one year prior to admission. The labor had been severe, and had been followed by some hæmorrhage, fever, abdominal pain, and a vaginal discharge, which had continued. Vaginal examination revealed the facts that the uterus was somewhat enlarged, that it was movable, but that it was posterior.

On January 27th, after proper preparation of the pa-

tient, and under ether narcosis, the cervix was dilated, and the uterine cavity curetted and irrigated with a 1-to-4,000 bichloride solution. The anterior vaginal wall was next incised, and after the bladder had been separated from the uterus the fundus was caught by bullet forceps, drawn forward, and fastened to the vaginal flaps by means of two heavy catgut sutures. The vaginal wound was closed with the aid of interrupted catgut sutures. The patient's convalescence has been uneventful, her bodily temperature hardly rising above normal. The menstrual flow was re-established on February 22d; it was painless, and of four days' duration. In March it was noted that the uterus had remained in good anterior position.

S. C., a single woman, was admitted to the gynæcological ward of the City Hospital on December 10, 1895. She stated that her first menstrual period occurred during her ninth year, and that the menstrual flow had been regular and of the monthly type until recently. It had always been accompanied by pain in the sides and back. Eight months ago she had had a child, and since that time her health had been poor, as she had suffered from menorrhagia and metrorrhagia. Vaginal examination revealed an enlarged, tender, and retroplaced uterus. On December 14th, after the patient had been prepared in the usual manner and under ether narcosis, the cervix was dilated and a curettage performed. After this, Mackenrodt's operation was performed. The patient's convalescence was uneventful.

On December 30th, as she complained of pain in her lower abdomen, an exploratory laparotomy was performed. The position of the uterus was satisfactory. The appendages were somewhat adherent, but were otherwise normal. After the adhesions had been broken up, and the peritoneal cavity had been freely irrigated with hot saline solution, the abdominal wound was closed by a single row of silkworm-gut sutures passing through all the different layers of tissue. The wound healed primarily, and the convalescence was uneventful. On Janu-

ary 22d the patient was allowed to leave her bed. On January 29th it was recorded that on vaginal examination the uterus was found to be anterior, and that the patient had stated that her pain had disappeared.

M. G., a widow, thirty-two years of age, was admitted on November 14, 1895, to the gynæcological ward of the City Hospital. She stated that her first menstrual period occurred during her fourteenth year; that menstruation had been regular and of the monthly type, but painful before the flow was established, and that this pain was felt in the lower abdomen and small of the back. Her last menstrual period had occurred on November 1st, and since that time she had been suffering from metrorrhagia. She also stated that three years ago she had undergone a laparotomy for the removal of an ovarian cyst, and that this had been accompanied by an attack of cystitis. Three months prior to admission to the hospital she had undergone a curettage and a trachelorrhaphy. Vaginal examination revealed the fact that the patient had a large proctocele, that stenosis of the external os existed, and that the uterus was retrodisplaced.

On November 22, 1895, after the patient had been prepared in the usual manner, and had been placed under ether narcosis, the cervix was drawn down, and after a probe had been passed into the cervical canal the latter was incised and dilated. The uterine cavity was then curetted, and after irrigation an Outerbridge dilator was introduced into, and left in the cervical canal. After this, the anterior vaginal wall was incised, the bladder separated, the uterus anteverted, and attached to the anterior vaginal wall, according to the method of Mackenrodt, of Berlin. The peritoneal cavity was not opened. The patient's convalescence was uneventful, excepting for the fact that the necessary catheterism lighted up the chronic vesical inflammation which had existed for some years prior to the last operation. This made it necessary to wash out the bladder with a boric-acid solution. On December 11th it was noted that the wound of

the anterior vaginal wall was healed excepting at one small point, and that the uterus was anteverted and adherent. On December 20th the cervical dilator was removed, the canal being well opened. On January 29th it was found that the position of the uterus was satisfactory.

S. S., a single woman, eighteen years of age, was admitted to the gynæcological ward of the City Hospital on December 12th, 1895. She stated that her first menstrual period occurred during her eleventh year, that menstruation had been more or less irregular, and that it had been accompanied by pain before, during, and after the flow had been established. She had had no children, but in May, 1894, she had had a miscarriage at two months, which had been followed by a long illness of a feverish nature, and by severe pain in the lower abdominal region. This pain had been rather more severe on her left side, and had radiated into the small of the back and down both thighs. It had been increased by the upright position or by walking. She also stated that she had had syphilis, the first symptom of which had appeared during June, 1894, and that in March, 1895, she had submitted to a curettage, which procedure had temporarily improved her condition. Vaginal examination revealed the fact that the uterus was enlarged, tender, and retroplaced, and that an enlargement of the right ovary existed.

On December 30th, after the usual preparation, and under ether narcosis, the anterior vaginal wall was incised, the bladder separated, the fundus of the uterus drawn forward, and the vesico-uterine fold of the peritonæum incised. On examination, the left ovary and tube proved to be normal, but the right ovary was found to contain a cyst, and this was removed. The uterus was then attached by three catgut sutures to the anterior vaginal flaps, which were united by a continuous suture of catgut. On January 4th there was a slight elevation of the patient's temperature, and she complained of colicky uterine pain. Vaginal examination revealed the

fact that the uterine body was acutely flexed on the cervical portion, the sutures having been placed too low down on the body. Under chloroform anæsthesia the sutures were removed and some of the adhesions broken up, and the uterus placed in a better position. It was found that these adhesions were already very strong. The patient progressed favorably until January 15th, when she was attacked by scarlet fever, and was removed to the Willard Parker Hospital.

In the cases herewith reported, with the exception of the fifth, the vesico-uterine fold of the peritonæum was not divided. The failure to do this necessitated the performance of a second operation at an early day in Case I. The writer believes that in all cases thought to require this operation, the vesico-uterine fold of the peritonæum should be divided, and the exact condition of the annexa determined by aid of sight as well as by touch. This addition to the original technic does not in any way increase the slight risk which the patient runs who is subjected to this procedure. The opposition to this method of treating uterine retrodisplacements which has been encountered of late by Mackenrodt has, Dr. Vineberg believes, been due to the employment of faulty technics. In this view the writer concurs. Recently it has been stated in various journals that Mackenrodt has abandoned this procedure. In view of these reports, the writer communicated with Dr. H. F. Brownlee, of Danbury, Conn., who had recently visited Dr. Mackenrodt's clinic, and asked him to express his opinion as to the correctness of these statements. He has received the following reply:

My dear Doctor: In reply to yours of yesterday, I have not seen the statement you refer to, and can hardly

believe that it is reliable. I spent two months in Berlin last summer (June and July), and took a private course with him during that time, and became quite well acquainted with him. At that time he was thoroughly satisfied with his operation, but was making a strong fight against the method used by Dührssen, Olshausen, and others—i. e., the fixation of the fundus with silkworm gut. He makes a point that where only catgut is used, the uterus is held only by adhesions, and that these adhesions do not interfere with pregnancy, while a silkworm or any other non-absorbable suture is a serious danger if pregnancy takes place. He told me that in a great number of his cases the patients had borne children since operation with no trouble whatever.

He has said for a long time that trouble would arise from these permanent stitches, and a short time before my departure his prophecy was fulfilled in a case at the Charité, where a laparotomy was necessary to delivery. A Porro operation was done, I think by Gusserow, resulting fatally, and the case was exhibited at a subsequent meeting of the Berlin Gynæcological Society.

I believe Mackenrodt to be a thoroughly honest man, and if he were convinced that his operation was wrong he would readily acknowledge it, but I do not believe the statement true, for I think it impossible for him to have made such a radical change after two years' experience. and being so well satisfied at such a recent period.

I have done two operations here; my first was all right, and the result so far good. It was done in October, 1895. My second was unfortunate through some faulty catgut, which gave way on the second day, allowing the fundus so much freedom that I did not get adhesions firm enough to hold, and in three months the fundus was again in the posterior *cul-de-sac*. I did the operation over again, four weeks ago, and used kangaroo-tendon sutures for the fundus (two). The result so far is good. Of course, both of these cases are too recent to form definite conclusions, and neither patient has become pregnant, so the cases are of no use to you.

The writer believes that if the process about to be described is adhered to, the results obtained will prove entirely satisfactory, and that the operation of vaginal fixation will, in time, be proved to be the most satisfactory means at our command for the permanent relief of those suffering from retrodisplaced uteri. The patient is prepared as for a vaginal hysterectomy, and is placed on the table in the dorsal position, with the thighs flexed and held in place by a Clover crutch. As in this class of cases there is more or less endometritis, it is well to begin the operation by curetting the uterus with a sharp curette, gauze not being placed in the cavity. Any existing laceration of the cervix should be repaired, sutures of catgut being used. These steps having been taken, the cervix is grasped and drawn downward and forward by the aid of a bullet forceps. Then a portion of the anterior vaginal wall, about three quarters of an inch below the meatus urinarius, is taken up in the same way and drawn forward and upward, thus stretching the wall. An incision is made, beginning at the last-named point and continuing to the cervix. If this wall is more or less prolapsed, the incision, instead of being straight, should be oval, allowing for the removal of sufficient tissue to overcome this defect when the sutures which close the vaginal wound are placed. These flaps are dissected from the inferior surface of the bladder, into which a sound is passed, and by its aid the thickness of the bladder wall is estimated and its lower border defined. A needle, threaded with pedicle silk, is passed through the inferior edge of either flap and tied, the ends being kept long. These serve as retractors, and, the flaps being held aside, a curved transverse incision is made at the cervico-vesical junction. The bladder is freely separated from the

uterus by blunt dissection with the finger, the vesico-uterine fold of peritonæum being divided by the aid of scissors. The patient's hips are elevated, which allows the bladder and intestines to gravitate from the uterus, the fundus of which is brought into view and is seized with a bullet forceps and drawn forward. The ovaries and tubes are inspected, after any existing adhesions have been broken up, and if diseased are removed. A suture of chromicized catgut or kangaroo tendon is passed by means of a curved Hagedorn needle through the left vaginal flap at a point slightly distant from its superior margin, then through the muscular tissue of the anterior uterine wall, close to the fundus, and then through the right vaginal flap near its upper margin. A second suture is passed in the same way, about one third of an inch below the first. The uterus being well anteverted, the sutures are tied loosely. The balance of the wound in the anterior vaginal wall, after free irrigation with saline solution and the application of hydrogen dioxide, if there is much oozing, is closed by means of interrupted sutures of horsehair, and the wound is sealed by painting it over with a ten-per-cent. solution of iodoform in ether. A small quantity of gauze is placed in the vagina for the purpose of effecting drainage, and an antiseptic pad is applied to the vulva.

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