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KATE CAMPBELL MEAD, M. D.,

MIDDLETOWN, CONN.

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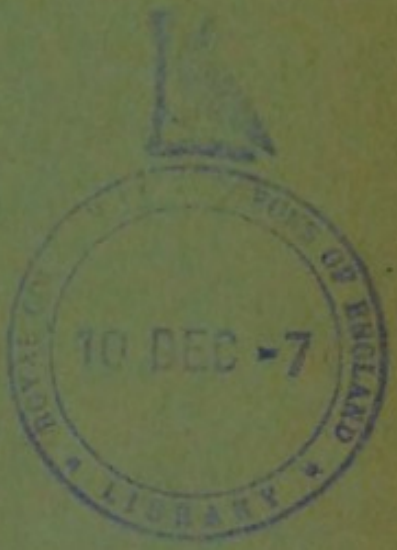

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NONOPERATIVE TREATMENT OF PROLAPSUS UTERI. THE SCHATZ PESSARY, ETC.*

By KATE CAMPBELL MEAD, M. D.,

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It is not entirely to the often maligned obstetrician that many cases of metritis and malpositions of the uterus are due, but rather to the ignorance of mothers as to the care of their own health and that of their growing daughters, and to the negligence of the family physician in teaching women and girls the rules of physiology and hygiene to be observed during their menstrual periods.

Metritis, as caused by congestion of the uterus from any cause, is one of the most common forms of uterine trouble among the unmarried as well as among those who have borne children. "The more children, the more metritis," is perhaps true, but the relaxed condition of the uterine muscle during every menstrual period predisposes it to a lowered muscular tone, and this in an anæmic woman may cause an actual loss of muscle fibre which may be replaced by less complex connective tissue. Improper clothing, straight front corsets, heavy skirts, tight stocking supporters, constant standing or long protracted sitting, wet

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feet or cold hips—all of these external causes as well as internal or intraabdominal pressure upon the great vascular trunks—create a passive congestion in the pelvis which may be transformed by any germ disease into an acute inflammation of the uterus and its annexa. Many investigators have proved that bacteria can wander through membranes and multiply in adjacent structures. For example, Capaldi (1) conducted experiments on pregnant and nonpregnant guinea pigs to determine whether colon bacilli could wander from an impervious or obstructed colon to the uterus, with the result that he found colon bacilli not only in the uterus, but also in the amniotic fluid and peritoneal cavity after the death of the animal. It would, therefore, seem that chronic constipation might alone account for many of the cases of intrauterine infection in women. Bacteria, wandering from a distended bowel, find congenial soil in the congested tissues of the pelvis, and thus cause an already heavy uterus to become enfeebled through autointoxication. An inflammatory exudate is then thrown out, involving other adjacent organs, binding these organs into any abnormal position, and thus a condition of chronic metritis and parametritis results.

It has been said that the constant to and fro movement of the uterus and the organs about it is essential to their health. This to and fro motion cannot be accomplished unless the breathing is deep and free, or unless there is alternate pressure and relaxation to cause a free flow of

blood through the veins and lymphatics of the pelvis, and thus give gymnastics to the muscle fibres in the uterine supports. Constricted ribs cause congestion of everything below the point of constriction, and induce more or less paralysis of the diaphragm and of all the abdominal organs.

In such cases it is impossible to cure the congestion of the uterus unless external as well as internal details are attended to. Among the external details there must be attention to exercise, clothing, etc. Proper gymnastic exercises will so strengthen the abdominal and spinal muscles as to remove the need of artificial support. After these muscles have regained their tone the circulation of the entire body will be equalized and the nervous system relieved of a great source of irritation. A woman's skirts should not be heavy, nor should they bind her with their bands. They should be fastened to her waist and hang from her hips. Her petticoats should be warm and of light weight, and she should wear a comfortable, close fitting undersuit. No stocking supporters are free from fault, but those which pass down the sides of the thighs are less harmful than the "straight front" kind. Garments may be fashionable and stylish, but at the same time they should be comfortable and hygienic.

To keep a good figure depends, however, on daily gymnastics, a healthy diet suited to individual requirements, proper bathing, pure air, and nasal breathing. If women have not perfectly natural forms, and are already victims of

chronic pelvic congestion and inflammation, they are in reality semiinvalids, and sooner or later they complain of the symptoms of metritis with its accompanying constipation, digestive troubles, malnutrition, and nervousness. There results generally a malposition of the uterus and its appendages, among which the most common are retrodeviations of a greater or less degree, from simple retroposition to complete prolapsus uteri. As to the causes of this complete prolapsus Garrigues (2) says: "Chronic prolapse is nearly always due to childbirth. During pregnancy the vulva, the vagina, the uterine ligaments, and the pelvic connective tissue become infiltrated with serum. During labor these same organs are subjected to great distention, contusion, and laceration. After the birth of the child, the uterus often remains too large and heavy, in consequence of subinvolution. When the fasciæ and the muscles of the pelvic floor which contribute to its support are injured, too great a burden is thrown on the ligaments that sustain it from above, and they are weakened and elongated. As soon as retroflexion is established, the intraabdominal pressure contributes to the displacement. During the lying-in period, when all the tissues are soft, succulent, and yielding, the very weight of the urine accumulating in the bladder is likely to start a cystocele. Thus lack of support from below and above combine with weight, pressure, and dragging, to displace the uterus after confinement. More rarely the prolapse is due to a tumor

in the uterus which increases its weight, or an abdominal tumor that crowds it down."

As to the treatment of prolapsus uteri, he says: "They (pessaries) are used much less than formerly, operations having taken their place" (3). He has discarded all but Emmet's in cases of retroflexion or retroversion if operation is refused. And again (on page 246) he makes the statement that: "Pessaries are a poor makeshift, and are much less used nowadays than formerly; but there are always patients who from one cause or another cannot be operated on and are much benefited by wearing a pessary permanently or temporarily." And again, in treating of prolapse, Garrigues says (on page 257): "Common pessaries are of little use, because they do not find the necessary support from below. . . . But the proper treatment is surgical." He suggests the possible use of a large ring pessary, and of the barbarous vaginal stem and cup, than which not even complete prolapse is more uncomfortable.

Surgeons have devised numerous operations for replacing retroverted or retroflexed uteri, and for curing endometritis. In some cases it is doubtless expedient to subject the patient to operation if all the conditions are favorable for her speedy convalescence and permanent cure; but in other cases either the patient refuses operation or her nervous system would not react well from the shock of an operation. Moreover, in such cases internal massage is often of great efficacy, and the name of Thure Brandt should be known as well as that of Alexander in connection with

the cure of uterine displacements; students should be taught the methods of the Brandt massage (4) as carefully as the various surgical operations for replacing and anchoring a uterus. Many a woman can be benefited more by judicious massage of the pelvic tissues together with appropriate nonsurgical gynæcological treatment than by surgery. The massage treatment is useful where there is no active inflammation. It removes exudate, stretches adhesions, replaces the dragging uterus or ovaries, and strengthens all the supports, but the massage should be supplemented for a time with pessaries or with rubber colpeurynter bags filled with mercury. These bags can be used several hours every day in a recumbent position, but it is necessary to have such treatment, as well as the massage, given by an experienced gynæcologist.

To Dr. Oskar Bürger, the first assistant in Schauta's clinic in Vienna, I owe many invaluable suggestions as to nonoperative gynæcological treatment; for example, the hot air treatment of chronic inflammations; chloral tampons for pain; formaldehyde cauterizations for endometritis; rectal injections of ergot for uterine hæmorrhage; a colpeurynter bag filled with mercury as an aid to replacement of a retroverted uterus; ice cold applications for an acute inflammation; patient persistence with Brandt massage to stretch adhesions; and the Schatz pessary in cases of more or less complete prolapsus uteri.

None of the ordinary pessaries on the market has been entirely satisfactory in relieving cases

of procidentia, and perhaps no artificial support will ever be made to take the place of normal perinæum and normal suspensory ligaments, but the most satisfactory artificial aid in this respect for cases of prolapsus uteri with rectocele and cystocele is a pessary invented by Professor Schatz, of Rostock University in Mecklenburg, Germany. This particular pessary is saucer shaped, made of hard rubber, and perforated liberally so as to allow for the exit of secretions. It is made in many sizes from 6 cm. to 9 or 10 cm., and is the only one I have ever seen which can be retained in cases of prolapse or procidentia with torn perinæum and flabby vaginal walls. The old cup pessary is ruinous to the patient's mucous membrane, of little value as a support, and actually harmful if worn long. The Hodge or Thomas Smith pessaries cannot be retained unless the pelvic floor is whole. The ring pessaries are of more value than some of the others, but frequently are so bulky as to be uncomfortable. Professor Schatz (5) formerly recommended the egg or ball pessaries in cases of large inoperable genital prolapse. These pessaries are hollow, very light in weight, and are frequently used in the clinics abroad, particularly in Rome. The suction of the vagina holds this artificial egg in place with such strength that frequently to remove the pessary it is necessary to soften a small area in its surface with ether or chloroform and extract it with tenacula or forceps.

Professor Schatz, having used these various pessaries and realized their imperfections, made

this "Schalen" or saucer-shaped pessary, which is so anatomically correct that it will support a complete prolapsus, even if the pelvis is tilted or the perineal tear one sided (7). He says: "These pessaries, of suitable size and proper thickness of rim, generally give such good satisfaction that, as I feared, they have found too ready a service among physicians. They permit the patient and physician frequently to neglect an operation which should be preferred to the use of the pessary" (6).

For cases where the saucer pessary in large size is not efficient because of the weight of the uterus and an unhealthy discharge, and also for cases where the patient cannot learn to remove and replace it, Professor Schatz has adapted a funnel shaped pessary which is easy to remove, and which is fashioned on the principle of the old cone shaped, clubbed, handled, or other stem pessaries, but which seems to him more correct in shape and more satisfactory in every way than any of the others. This pessary, with its conical valve in small or large sizes, is especially good where there is continuous dribbling of urine, or prolapse of the vagina. The stem lies in the opening of the perinæum against the levator ani, and acts as a lever for holding the "valve" of the pessary in place, parallel to the anterior vaginal wall. This stem must not be too long or too thin; in the former case the patient would be conscious of it, in the latter it would be pressed out of place. The other handle pessaries become tilted by various movements, but the fun-

nel shaped pessary retains its position whatever the patient is doing. It has but one large opening, which, however, is not needed for drainage, because the patient must remove it every night and clean it thoroughly herself. This funnel shaped pessary does not correct malposition of the uterus, as the saucer pessary does, but it is so much easier for the patient to remove that there are many cases in which its use is preferable. Schatz reiterates the plea, however, not to allow the patient to become so pleased with the pessary as to be willing to forego a needed operation if an operation would be likely to be successful. These Schatz pessaries are not as yet manufactured in the United States, nor have I obtained reports from all that have been imported and used by other physicians.

I wish to report some of my cases, among which there has not been a single failure, and also a case of Dr. Ellen H. Gladwin, of Hartford, who used a medium sized Schatz pessary in a patient who had refused operation, even though she had been obliged to wear two pessaries in order to keep in place a heavy prolapsed uterus. This patient is now perfectly comfortable with the Schatz saucer pessary. Of my own cases I cite the following:

Case I.—Mrs. N., 60 years of age. The perinæum torn nearly to the rectum, prolapsus uteri with cystocele of twenty years' duration. Patient had worn napkins and had suffered from ulcerations and intense pruritus. She was first seen by me in 1897. No pessary could be used on account of soreness and discharges, and opera-

tion was refused. For one year she wore tampons with some comfort, and then round hard rubber pessaries, at intervals, for several years. Finally, the round pessary caused obstinate constipation from pressure upon the rectum, and its removal or replacement caused great pain, owing to the brittleness of the vaginal outlet. From the first hour of wearing the Schatz pessary the patient experienced great relief. There was no constipation, no fear of losing the pessary during defæcation, and practically no discharge or pruritus.

Case II.—Mrs. J., 65 years of age. The perinæum was ruptured to the edge of anal orifice, with complete prolapsus uteri, cystocele, and rectocele. The patient had worn stem and cup pessary with great discomfort. A large doughnut shaped pessary could be retained while moving about the house, but not during defæcation or much exertion. A Schatz pessary of smaller diameter is now worn with complete relief of all the symptoms.

Case III.—Mrs. H., 57 years of age. Patient has had prolapsus since the birth of her only child, 19 years ago. She worked in the field with bandage as supporter, and has become a nervous wreck. The insertion of a large Schatz pessary, 8.5 cm. in diameter, has given perfect support to the uterus and relaxed vaginal walls, so that she now works comfortably, and her nerves are much less irritable.

Case IV.—Mrs. N., 45 years of age. Patient was badly torn at the birth of her last child, 13 years ago, and has tried to wear all kinds of pessaries to cure a complete prolapsus since that time without any relief. The Schatz pessary, 8.5 cm., is now worn with perfect comfort.

Case V.—Mrs. J., 55 years of age. Patient was operated on in 1900 by Dr. Bache Emmet for torn perinæum with rectocele and cystocele. The perinæal body was well restored and the rectocele relieved, but the remaining cystocele has given a great deal of trouble. The vaginal outlet is very small, making the insertion of any pessary difficult. The Schatz pessary, 6 cm., was inserted and completely relieved the cystocele, but caused an ache in the left ovary with pain down the left leg, where she had had a phlebitis. The pessary was, therefore, removed. The patient would be willing to have another operation performed, if she could be assured of being cured, but the walls of the cystocele are very thin and the bladder sags so heavily that its vaginal wall is deep purple in color.

Case VI.—Mrs Ha., 80 years of age. There is a complete procidentia, between ankylosed hips. The insertion of any hard rubber pessary was difficult, and none would remain in place during walking or defæcation until the Schatz pessary was used. This pessary is very comfortable, and the patient removes it herself every week for cleaning.

Case VII.—Mrs. B., 65 years of age. Patient is a nullipara. She has an elongated cervix uteri, with retroversion. The vaginal outlet is tense and hard. Soft rubber pessaries quickly spoiled, owing to acid secretions, and hard rubber retroversion pessaries did not lift the uterus so high that the cervix would not protrude from the vulva; small round doughnut pessaries closed the vulva for a time, but soon lost themselves in the vaginal fornix; cotton tampons were uncomfortable. Finally, a small Schatz pessary, 6.5 cm., was inserted with a little difficulty, but it gives complete relief to all her symptoms, actual and reflex.

Case VIII.—Mrs. B., 34 years of age. Patient has had five children in six years under rapid labors. The perinæum was badly torn and never repaired. She has had complete procidentia since the birth of her last baby, 6 months ago. The cervix is eroded, torn, and ulcerated. The uterine canal measures four inches in length. Tampons of ichthyol and glycerin, applications of tincture of iodine and carbolic acid to the endometrium, protargol and balsam of Peru to the cervix, brought about a good condition of the uterus and cervix. The largest sized Schatz pessary holds the uterus in perfect condition. An operation was positively refused.

Many gynæcologists all over Europe could doubtless make as favorable reports as to the value of Professor Schatz's pessaries as I have done, and although thousands of other artificial uterine supporters are being used daily by conscientious gynæcologists who must honestly confess that by these means they can help and sometimes cure their patients as well as by operations, a fellow countryman of Professor Schatz's, E. Runge (8), recently has tried to convince his readers that the pessary is a thing of the past in the treatment of prolapsus uteri, and that one of the many methods of operation must be chosen. Among operations there is none for the suspension of the uterus which entirely relieves the patient's symptoms, and surely the patient's feelings and not the surgeon's are to be taken as the criterion of either success or failure. Even if the uterus is removed, the stretched and ruined vaginal walls cause almost as much discomfort to the patient as did the prolapsed uterus. The dis-

tended rectum is uncomfortable, and so is the sagging bladder.

None of the operations which had for their aim merely a restoration of the perinæal muscles and of the anterior and posterior walls of the vagina have been entirely satisfactory to the patient, because the flabby, abdominal ligaments are of no use in holding the uterus where it belongs, and the concomitant retroversion requires further treatment by massage and pessaries.

Parsons (9) treats prolapsus uteri by injecting quinine into the broad ligament. This causes an effusion of lymph in the uteropelvic band within the broad ligaments. He has reported ninety-three cases of which he cured eighty per cent.

Gersuny recommended the treatment of cystocele and rectocele by injection of paraffin into the anterior and posterior walls of the vagina. This has given good results in some cases, but in others the pressure of the foreign substance caused necrosis of the tissues, and this method does not seem thoroughly practicable.

For the poorer class of patients who cannot obtain massage treatments in free clinics, and who object to operations of any kind, a suitable pessary must be used in order to give some relief to their discomfort. Possibly some of our great surgeons may invent a simple and speedy operation for the cure of such cases, but at present the operations for cystocele alone are tedious and bloody, while posterior colporrhaphy and perinæorrhaphy are of small value if there is a

heavy retroverted uterus pressing upon the posterior vaginal wall.

It is, therefore, at present fortunate that we have these new Schatz pessaries, as well as other nonoperative forms of treating misplacements of the uterus and its annexa.

165 Broad Street.

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