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A. milne

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REMARKS

ON

RETROVERSION OF THE GRAVID UTERUS.

BY

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RETROVERSION OF THE GRAVID UTERUS.

Of the various displacements to which the uterus is liable both in its virgin and impregnated state, retroversion is one of the most important. Ancient, and even the older modern authors, knew little of it as affecting the unimpregnated womb, and it was not until Sir James Simpson directed his attention to it, that it received the consideration which its undoubted importance demanded. Since that time—now nearly a quarter of a century ago—not a few luminaries have shed their quota of light on the interesting subject, and it is now somewhat less beclouded by the mists of conjecture and doubt, although no small amount of fallow ground, or rather debatable land, still remains; treatment, to wit, still being chameleon-like, many-complexioned, and begetting some acrimony, and no less contrariety of opinion and view. With regard to this deviation in the gravid uterus, our knowledge in point of time is more venerable. It was described by Ætius, Daventer, Mauriceau, and La Motte, and more thoroughly explained by Grégoire of Paris, and his pupil Levret. In this country, the palm for complete description and clear illustration is justly awarded to William Hunter, who had the opportunity of examining a fatal case which occurred in the practice of Mr Wall of London; and the deviation recalls his worthy name as readily as that of the stethoscope does Laennec, the écraseur that of Chassaignac, the *pelvis obliqué ovata* that of Naegelé; or as the ankle-joint operation reminds us of a Syme, vesico-vaginal fistula a Marion Sims, and the uterine sound and chloroform a Simpson.

It is of this latter displacement, that which occurs during pregnancy, that I would desire to speak, being drawn to the subject by one or two cases which have occurred in my practice, and notes of which I append.

Time of its Occurrence.—And first, with reference to the time of its occurrence. Here there is small diversity, much harmony and unanimity of opinion, and because there is no room for divergence. Therapeutics may occasion much discrepancy and antagonism for many days to come yet, but here is a clear matter of mathematical certainty. The long axis of the uterus may be, in size, under that of the superior strait up to the fourth month inclusive, or so; but

after that it is in excess, and the displacement becomes a physical impossibility. The organ can then no more topple to prostration than can the pyramids or everlasting hills. It is true that some cases have extended to the fifth or even the seventh month of pregnancy,[1] but then they were initiated at an earlier time, and their prolongation to this advanced period involved a considerable squeeze, and, as a rule, an unhappy termination.

Causes.—With respect to the causes, there is less harmony of view, there is much more of theory and speculation; because, evidently, more room for conjecture. I may give a quotation or two to show this:—

Dr R. Lee[2] says, "It is a consequence of undue accumulation of urine in the bladder."

Dr Ramsbotham avers,[3] "The cause of this accident is most frequently, if not always, to be traced to an over-distended bladder." Dr R. also mentions lax uterine supports, and a large pelvis, or a deformed brim, etc.

Denman also views the bladder to be the greatest sinner in the case. He says,[4] "It is more reasonable to conclude that the retention of the urine precedes the retroversion, if we do not allow it to be a cause without which the retroversion cannot exist."

Merriman also impeaches the bladder.

Hunter laid much stress on pelvic causes. He says,[5] "The pelvis which is most capacious below, and narrowest above, will be most disposed to such disorders."

Blundell remarks[6] that, "in four cases out of five, the accumulation of urine in the bladder is the cause."

Boivin and Dugés say,[7] "We are disposed with Callisen to rank, among inducing circumstances, a considerable curvature of the sacrum backwards, and great prominence of the sacro-vertebral angle."

Tyler Smith,[8] in his beautifully concise and scientific work, while noticing the commonly accepted view that an over-distended bladder is the chief displacing cause, believes that many cases occur from "impregnation of the uterus already retroverted;" that is to say, the deviation existed prior to conception, and was not rectified by it.

Churchill,[9] in his elaborate and thumb-worn book, enters minutely into the various causes, assigning considerable prominence to the relaxation of the uterine ligaments and vagina, and the kind of pelvis; but he evidently has a considerable grudge also against the bladder, for he remarks, "In the majority of cases, it will be found

[1] Bartlett, Bibl. Méd., t. lxxvi. p. 123.
[2] Theory and Practice of Midwifery, p. 207.
[3] Obst. Med. and Surgery, 4th ed., p. 650.
[4] Introduction to Practice of Midwifery, 7th ed., p. 90.
[5] Med. Observ. and Enquirer, vol. v. p. 389.
[6] Diseases of Women, p. 5.
[7] Diseases of the Uterus and its Append., trans. by Heming, p. 74.
[8] Manual of Obstetrics, p. 128.
[9] Diseases of Women, 5th ed. p. 422.

that the urine has been retained for many hours." It is just possible that this painstaking author may mean that the urine is retained as a result of the displacement; but we rather opine that he views the retention as the cause more than the consequence of it.

Dr Matthews Duncan[1] thinks that some cases at least may be explicable on the ground of a "diminution" of what he calls "the retentive power of the abdomen."

Lastly, Dr Edward Marten,[2] in his ample and able and very theoretical book upon the subject, attributes it to "defective contraction of the round ligaments, and excessive action of the abdominal muscles."

From these extracts from defunct and living authorities, which are a fair representation of the views held on the subject, and which might be easily multiplied, it will be seen that no little discrepancy of opinion obtains with reference to causation; some laying stress on one cause and some on another. Many—the majority in fact—blame that useful viscus, the bladder, sadly; others lay emphasis on abdominal pressure; others on the kind and character of the pelvis; some say it is all round ligament; and some declare that it is the offspring of more or fewer of these causes conjointly.

Now, I shall dogmatize as little as possible in reference to a subject which probably may ever afford ample scope for theory, and content myself with indicating the views I have been led to adopt from the observation of two or three cases of the disorder. What, then, are the causes of retroversion in the gravid state? Are they few or many? Is there a *sine qua non?* In order the better to answer the question, we may glance briefly at the position and relations of the uterus, its connexion with neighbouring parts, and the changes which pregnancy effects. The uterus is poised in the middle region, and near the brim of the pelvis, having the bladder in front and the rectum behind, with both of which it is connected by peritoneum and areolar membrane. It is supported below by the vagina, together with the perinæum, and above by the broad ligaments going to the abdominal wall and the sides of the pelvis, and the round ligaments going towards the groin. These are pretty intimate connexions, and it would seem as if the organ should be well restrained; but in spite of them it possesses great latitude of movement (a mobility essential to the due performance of its main function), and yields in any direction to moderate pressure; resuming, however, its normal position on the withdrawal of the force. You can, for example, easily hook down the womb and produce a prolapsus; you can antevert the cervix, and produce a retroversion; or you can retrovert it and produce an anteversion. In short, the subtle changes of the

> "Dolphin, tumbling in wild glee,
> And plunging in wild pastime,"

are nothing to it. This great mobility led the distinguished Cru-

[1] Researches in Obstetrics.

[2] Die Neigungen und Beugungen der Gebärmutter nach vorn und hinten.

veilhier to remark, that the womb had no proper axis at all; and, indeed, it is almost as prone to itinerancy as the Bedouin, or those "creatures wandering o'er God's green earth, the Gipsies," who have no settled home. The organ is thus normally a prey to easy displacement, but restores itself by the power and elasticity of its supports. In those who have borne children, the liability to deviation is often enhanced. Here pathological changes are superadded, for however natural the processes of pregnancy and parturition may be, it is rare to find these wanting. The broad and round ligaments get weakened and distended, and the vagina and perinæum from various causes—pressure, congestion, inflammation—lose tone and become relaxed. Thus a new source or occasion of errantry is imparted—a new license to the womb to wander; more easily,

> Up or down, from side to side,
> The mobile organ now may glide;
> Backwards or forwards, or a freak
> In the direction of oblique.

As a rule, the more common consequence of these changes is a sinking of the womb; it is prolapsed to a certain extent, and this prolapsus involves a change of axis. It loses its anterior obliquity, becomes either vertical or more generally oblique, with the fundus leaning sacrumwards; in other words, its axis now corresponds more with that of the pelvic outlet. Retroversion is thus initiated, although only, it may be, to a moderate extent, and inadequate to the production of inconvenience or functional ill, and the enfeebled supports being unable to recall the organ to its normal site, the deviation continues.

Pregnancy inaugurates a new element of disturbance. After impregnation, an electric message, if we may so speak, is sent from the ovary to the womb—an unseen and occult or mystical influence passes between the two—and a determination of blood to the uterus is the result. Congestion thus succeeds conception, and enlargement—"a real hypertrophy"—goes on with steady pace. More especially is the growth at this time confined to the fundus, this part being the first to develop its "embryonic fibres," the body coming next in order, and the cervix, of denser texture, expanding or developing somewhat later. We have now the balance of the uterus disturbed, it is top-heavy, and with the axis altered, as before said, from that of the inlet to a direction approximating to that of the outlet, and moreover, not being able to calculate on adequate support from its ligaments, nor from the relaxed vagina and perinæum inferiorly, the risk of prostration (posterior reclination) is much more increased. One thing alone is now needed to complete the impending evil, and that is, the absence of posterior support. In unusually large pelves with deeply concave sacrum, this desideratum is supplied; no buttress or shore is offered to the reclining fundus, and down it gravitates into the hollow of the sacrum, like some fine pile whose stay has been cut away.

The moderate retroversion before spoken of, which enkindles no dynamical symptoms even, is now exaggerated into the horizontal displacement, which is an exigent and serious one, and fraught with certain distress.

This theory of the deviation, it will be observed, magnifies the predisposing causes, more especially the pelvic one. In short, according to it, the "predisposing causes" are sufficient of themselves to precipitate the deviation—to induce complete retroversion. Given a top-heavy uterus, not much exceeding the fourth month, lax ligaments broad and round, a flaccid vagina, a flabby perinæum, and a deeply-excavated sacrum,—and you have the complete complement of prerequisites for the overthrow of the womb, without assaults from the abdomen or bladder. The cases I have recorded support this teaching—uphold these views; for their origin could not be traced to, or connected with, any unusual or violent physical effort or force on the part of the patients; neither was the bladder primarily culpable.

Exciting Causes.—This view further dwarfs the exciting causes somewhat, or rather annuls them. They probably have their place, however, as conspirators with others in not a few cases, as working or acting in concert with other causes. Take the bladder first as the supreme sinner—the most potent exciting cause, according to the majority of authors. Well, it is next-door neighbour to the womb anteriorly, and when it is over-distended it must unfailingly bear upon it, and press it back to a certain extent, at the same time, from its connexion inferiorly with the cervix, elevating this part, and taking the feet from the uterus, if we might so express it; but then it must have a co-operator in an unduly excavated sacrum. Did it meet with commensurate resistance behind—"a foeman worthy of its steel"—in other words, an average or typical pelvis, an ordinary sacrum, it would no more succeed in overthrowing its associate than would a pop-gun the fortress of Gibraltar, or a few foolish Fenians the Colossus of British power! Its true place, then, would seem to be that of a joint-labourer on some occasions with others. And this position or status, too, it possesses not naturally, but accidentally; for nature never places one organ as the enemy or assaulter of another, but rather more felicitously as its support, its helpmate, its friend. The distention of the bladder, in short, is an unnatural thing. And in reference to this over-fulness, a remark or two may be made. The common view and explanation of it is this: Your lady has been placed in some position of restraint—mayhap out at dinner, or the opera, or at the theatre; or engaged in some soul-absorbing pursuit, say profoundly entranced with the latest sensational romance; and while her bladder, like her chalice of joy, has been filling to the brim, she has failed to empty the vessel when safety required it. Now, while this may hold true in some cases, I believe many more may be quite differently and more truly explicated. I opine that the cause is oftener material rather

than moral; that instead of mental absorption, diffidence, or modesty, it is simply the pressure of the anteverted cervix on the bladder that leads to the retention and distention; that the latter is the direct offspring of the displacement. The order is this: Moderate retroversion first. This leads, unless there be much flexion, to pressure by the cervix on the bladder or on the urethra, then follow incomplete evacuation and retention, and the distended bladder now bears down the partially retroverted womb. It only assaults its neighbour when it has its floodgate coolly stopped. It comes in as Blucher did at Waterloo, and makes the downfall of the enemy more complete. It has thus, if we may so speak, its revenge, paying back the hurtful intrusion of the cervix on its domain by still further bearing down the fallen fundus, and opposing its rise. The bladder, then, though not innocent, is not so peculiarly peccant as some would proclaim it, and from the steeple-top, as it were; it only co-operates with others, and, barring these, would be indubitably impotent. In fact and in fine, the chief crime with which it may be fairly impeached is that of trampling on a fallen foe, of aggravating an existing retroversion—of maintaining a displacement initiated without its aid; its ability, or capability of doing so, being the result of the displacement itself.

Action of Abdominal Muscles, etc.—Take now the other forces which are often credited with the displacement. The female may have been lifting a heavy weight, or stumbled while walking, and suddenly endeavoured to avert a fall. She may have been laughing or coughing violently, or straining at stool from the operation of a cathartic, or some morbid condition of the bowel. These are, no doubt, causes of some value; but they would be nowhere as factors without the coexistence of others. They only serve to complete an already inchoated deviation, or to perfect it in the presence and with the aid of the predisposing causes. Were it not so, we should have retroversion much oftener, for these exciting causes are in operation, so to speak, every day. The mass of our female "hewers of wood and drawers of water," who do the "rough-and-tumble" work incident to their humble lot, could hardly escape the displacement.

Other Views.—There is another view, which may here have a passing word. It is this, that the uterus (more buoyant than cork, or Leander himself), while making its still unexplained and apparently inexplicable and truly wonderful ascent into the abdomen, is caught by the sacral promontory, and falls by the shock. Well, it is said that "if you drive your waggon in a hurry you may hit against a hard corner;" and the womb may, if it is in a desperate chase, like hounds after their prey, get caught by the fundus, and thus be overturned. Still, how many cases of deformed brim, of narrow conjugate, are to be met with where the deviation has never occurred? I can recall many of these myself.

Dr Tyler Smith's explanation would seem to be less honeycombed —less open to assault, more plausible, more probable; for small blame

to a uterus retroverted prior to impregnation remaining so for a considerable time after. But are not the chances of impregnation fewer in cases of flexion? and are not the probabilities great that the uterine changes following conception will rectify the displacement? They do so in most cases of flexion; for do not obstetric surgeons, after failure with tents, and sound, and pessaries, sigh for the advent of pregnancy as the most radical cure, with all the yearning of the exile for home, or the thirsty hart for the crystal brook?

Summary.—But to sum up now. I believe that there are certain causes—predisposing—indispensable to retroversion, and of paramount importance, as capable alone of inducing it; that there are also certain exciting causes which occasionally co-operate, but which must be viewed as subordinate. Moreover, that the most important cause is an unusually large pelvis, with a deeply concave sacrum. They may be thus tabulated:—

Predisposing and important.

1. Large pelvis, with deeply concave sacrum.
2. Relaxed supports and increased weight of uterus (leading to prolapsus, and change of axis to that of outlet).
3. Increased weight of fundus, rendering the womb top-heavy; due to impregnation, and characteristic of the earlier months.

Exciting and subordinate.

Forces acting on the uterus.

1. Distended bladder.
2. Action of abdominal muscles.

Symptoms.—In regard to the symptoms of retroversion in the gravid state, there cannot be much, if any, variety or difference of opinion. In the unimpregnated uterus a deviation of this nature—nay, displacements and flexions of various kinds—may exist for a while, at least, without symptoms; that is to say, without a sufficient amount of uneasiness to trouble the patient or arrest her attention, the organ being small (although some deny this, and declare that flexions always entail ill, and, like Prometheus's vulture, gnaw at the victim's vitals day by day); but in the gravid state, with a bulkier and growing womb, encroachment on contiguous organs—rectum or bladder—is inevitable. Collision may be deferred a bit if the uterus be much flexed—retort-like—but like to-morrow's sun, or the new moon, or destiny, or the downfall of Turkey, it will arrive. Symptoms are then inaugurated; they are no longer doubtful, debatable, mythical, like Homer or Ossian, but real and substantial, as any sort of thing can be. It is the bladder that first complains, being more sensitive than the rectum, and fluid, like murder, being more determined to be out, being less restrainable than the more solid material behind. Bladder symptoms, then, are the main,—they were almost the only ones in my cases. The cervix, too, is sharper, more pointed, than its antipodean uterine pole, and its poke is more provocative of pain. The rectum *tholes* much

better than its friend in front. If the pressure of the fundus uteri on it is shortlived, no suffering, even little uneasiness, may be occasioned; for while the anterior organ, the bladder, must be evacuated once at least in twenty-four hours, the rectum (in the female, that is to say) is content with an hebdomadal clearing out. A few grains of solid material in the bladder will occasion intense suffering, while the bowel will repose uncomplainingly for ten days under the pressure of a load many hundred times the amount. No thanks to the rectum, then, in general for a revelation of the displacement, but all praise to the sensitive bladder. By it we are warned in time, and were it less sensitive, or were its hints unheeded, the displacement might deepen into one of fatal character. Grave cases of this kind are recorded; the neap-tide of the disorder, so to speak, has passed by, whether from a foolish and culpable procrastination on the part of the patient, or a wrong diagnosis on the part of her doctor, and the more serious results of inflammation, sloughing of the bladder, peritonitis, etc., have ensued. Less prominent, but often troublesome, symptoms are those due to pressure on nerves, pains in the back, in the inguinal region, down the thighs, along the course of the crurals and sciatics.

Diagnosis.—Little need be said under this head. The detection of the displacement in general is not difficult. Retention of urine about the earlier months is suggestive of it, and rarely depends on any other cause. In such a case, an examination is imperative, and cannot be shunned. The finger passed into the vagina detects a tumour lying behind the posterior wall; transferred to the rectum, the same tumour is felt more or less blocking it up. The os is found upwards, looking towards the arch of the pubis, and if one can trace the uterus from cervix to fundus, suspicion will be strengthened and confirmed. The uterine sound is of course inadmissible here, the womb being laden with a valuable and living cargo, but the displacement may be made out without it. A flexible catheter may be always wormed into the bladder, and if a profuse outflow of urine results, it will further help diagnosis, at the same time being part of the cure. Error (a false diagnosis), one would think, would not be very likely here, despite its proverbial swiftness of limb; yet it is every now and then casting up, like the poor relation, or needy adventurers in all sorts of walks; and, we fear, may do so, so long as *humanum est errare* shall be a truthful label for, and no libel of, frail humanity,—that is, we fancy, till the last man "shuffles off this mortal coil." Blunders have been committed rather appalling, and rivalling in egregiousness those of our giants in surgery and medicine, including the renowned Liston, Velpeau, Pirogoff, and others. For example, the distended bladder has been mistaken for ascites, and tapping resorted to. Surely, we are apt to think, in such a case catheterism had been ignored. Had it been attended to, it would have saved the artificial and quite superfluous hole in the abdominal wall, which sometimes of itself

involved a fatal issue. Other cases have been viewed as pelvic tumours, despite the fact, as Churchill observes, that "these do not often occasion retention of urine, except when they are too large to be mistaken for retroverted uterus." This displacement has been confounded with anteversion even; but surely in such a case both cervix and fundus had to be searched for, as were Prester John, or the source of the Nile. Now you will find the one or the other in general without the aid of the lime light, or even a candle—I mean in the gravid state; in the unimpregnated womb I have known the cervix so displaced by tumour that it could no more be discovered, even by diligent and skilful search, than the scattered tribes of Israel, or that goal of anxious yet bewildered politicians,—a cure for Irish disaffection.

Treatment.—A few words may be said as to treatment. Reponement of the uterus is of course the first consideration, and ought to be set about without delay. Before attempting it, the superincumbent weight of a distended bladder must be got rid of. Catheterism is therefore the first step. When the bladder is emptied, there is room for the elevation of the fundus. A distended rectum may also exist, and bear down the fundus; it is not so frequent an obstacle; but if so, an enema is immediately demanded. When the bladder and rectum are both emptied, the coast, so to speak, is clear; the uterus is then in general easily made to assume its normal axis and position. The posture of the patient is of great value; it has much to do with success. The common obstetric position, left lateral, is good; that on the knees, with the nates elevated, and the head and shoulders depressed, is better. The advantages of this posture were pointed out long ago by Marion Sims, of duck-bill speculum renown—an able and worthy obstetric surgeon, as all here are aware. They are these:—The pressure of the abdominal viscera is removed; the uterus gravitates with these in the direction of the epigastrium, and is also assisted in its change of position by the entrance of the atmospheric air. In this auspicious posture, and under favourable circumstances, it has been found to bolt up, to recede even, "like a snail shrinking into its shelly cave." A little pressure may be required, however,—that of the finger on the fundus, introduced either by the vagina or rectum, at the same time, if need be, bearing down the cervix sacrumwards. This duplex movement—*basculation*—will rarely be found to fail. When the uterus is replaced, the next indication is to maintain it there until it goes safely above the brim; for up to the period when its increased bulk renders return impossible, there is a proclivity to a renewal of the deviation as a matter of course.

> "What boots it at one gate to make defence,
> While at another you let in the foe?"

For this purpose—that of maintaining normal position—posture again will sometimes be enough. Lying on the belly is lauded by

living and defunct authors, and undoubtedly it is the most favourable posture; but as, in this world, both with respect to men and mice, "nothing is constant but inconstant change," your patient will soon tire of lying with her back to the sky, and go to one or other side. Not much matter, for this is next in value to abdominal recumbency. It is as well, in addition, and indispensably necessary among those prevented from lying by the call of inexorable necessity, to plug the vagina carefully and well. Any soft pessary will prove an effectual prop—tow, or cotton, or linen, a handkerchief, or a neck-tie in a push. Soft, I say, because it is ungainsayable that a hard article in this canal (even less so than Aberdeen granite) only conduces to the relaxation and enfeeblement of it; bad policy, as undermining one of the chief pillars of the organ we desire to prop. If our pessary is steeped in an astringent solution, such as of tannin, gr. x. to the oz., so much the better, for this will impart tenseness to the vaginal walls, and increase the vigour of this inferior support. This firmness, however, is somewhat temporary, and must not be confounded with more permanent tone. The latter is best, if not only, obtained by internal remedies. And how vastly important is it to attend to these, if *our* view of the displacement be the right one! If an over-distended bladder, resulting from carelessness, or mental absorption, or diffidence, be the paramount cause, then physic may be thrown to the dogs and bats; but if lax supports (coupled with a large pelvis) be the chief thing, then prevention, which is "better than cure," may be achieved by strengthening the former. What have we in the long list of drugs—a chain of them almost long enough to engird the globe like the electric wire, or the martial airs of Britain,—what have we to accomplish this desirable end, the invigoration of the uterine supports? General tonics, such as iron, and special, such as nux vomica. The latter, as a strengthener of the viscera, occupies a high platform. Its power over a weak bowel, or a feeble bladder, is well known; over an ultra-mobile uterus its efficacy is sometimes equally great. If it is made to go hand in hand with iron, much good may accrue. The cold douche and the sitz bath are also valuable aids. The tone and strength conferred by these on the uterine supports may, in these cases,—that is, in females with unusually large pelves,—avert a future retroversion, some of the predisposing causes being thus removed or cured. The treatment may be summed up thus:—Evacuation of bladder, and, if necessary, of rectum; reponement of uterus; recumbency for a day or two; introduction of soft pessaries, steeped in astringent solutions, into the vagina, and, internally, general and special tonics.

Cases.—Case I., 8*th Feb.* 1864.—Called to see Mrs S., Jordan Lane, Morningside, said to be suffering from difficulty and pain in making water. On arrival, found that she had suffered, more or less, for several days, and had failed to be benefited by some of the

simple and popular diuretics, such as the acid tartrate of potass and spirits of nitre, which she had tried of her own accord. At first she could make a moderate amount, but now not more than a few drops could be passed, and that with effort and straining. She was not aware of having strained in any way, being unaccustomed to rough work, and she was free from cough, and regular in the bowels. Was certain that her symptoms—her difficulty of passing urine—came on gradually, and steadily deepened. She thought her trouble just due to her being "in the family way," for on former occasions, about the same period, she was similarly affected, though not to so serious an extent. On examination per vaginam, I found the canal somewhat obstructed by a tumour, which was also easily felt per rectum. Guiding the finger up towards the pubis, the os was easily recognised lying a little above the orifice of the urethra. I then traced the uterus along the cervix and body, and of course deemed the case quite clear. Introduced a small flexible catheter into the bladder, and drew off a very large quantity of urine, much to the relief of patient. The uterus did not "bolt up" on the evacuation of the bladder, but the merest show of pressure on the fundus reponed it, the os coming down as the former went up. Ordered her to lie in bed.

On calling the following day, I found renewed complaints of difficulty and pain in passing water, and on examination found a complete renewal of the displacement. Mrs S. had risen for a little, and this had proved sufficient to induce a relapse. Replacement was again easy, and after it I stuffed the enlarged vaginal canal with linen, a couple of handkerchiefs being greedily devoured. Enjoined rest for a day or two.

There was no renewal of the deviation, and patient went to the full time, and had a very speedy labour on the 10th of July (1864).

I may mention that Mrs S. is one of those desirable patients who have remarkably speedy labours, her children, owing to superabundance of pelvic room, coming home almost before one, however Jehu-like he may hasten, can arrive on the scene.

Case II., 12*th July* 1865.—Called to see Mrs L., pregnant for the fourth time. Woman with large pelvis, of pale complexion, and flabby muscles. Had suffered for a day or two from pain in evacuating bladder; urine only dribbled away. Had tried the Cockney's panacea—gin, but without any relief,—nay, apparently with aggravation of the distress. Inquired if she had been exerting in any way, lifting heavy weights, etc., but she could not recollect of such. An examination immediately revealed retroversion. The fundus was pressing on the rectum, and the os, somewhat indurated, bearing on the bladder, though only slightly; flexion existing to some extent. On passing the catheter, which entered easily, a good deal of water came away, but not so much as I ex-

pected from the history of the case. It was clear that, owing to the flexion, the pressure of the os on the urethra had not been very great. I pressed on the fundus, the patient being on her side, but it ascended slowly. I then altered her to Sims's favourite posture, and found it to enhance very much the facility of reposition, much less force being required, and the organ making a speedy and sonorous ascent. Plugged the vagina, and ordered rest. The former was retained for a day or two, but the latter was not carried out. There was, however, no return. Patient went to full time without further trouble, and was delivered on 4th January 1866, the labour being easy and short. I had anticipated this, and, although early on the ground, had only to superintend the third stage.

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