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THE OPERATIVE TREATMENT OF HYPERPLASIA OF THE UTERUS AND VAGINA, WITH SPECIAL REFERENCE TO THE CURE OF DISPLACEMENTS.[1]

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That the treatment of a large majority of cases of retroversion of the uterus, so far as obtaining radical cure is concerned, is unsatisfactory, is now a quite generally accepted fact. That an immense amount of good has been done in way of relief is fully conceded, and that in a very large number of cases complete cures have been the result, there can be no question. Artificial support by a great variety of pessaries has been the chief reliance, and under no circumstances could we dispense with them. We shall, by careful analysis, find, however, that most of the actual cures, so that no support is required, will be among unmarried women, and those who, being married, have never borne children, or having borne children, suffered no accident at parturition either by laceration of cervix or perineum. In these cases we shall invariably find the walls of the vagina in their normal relation, that of close apposition. But there remains a much larger class of cases among parous women where this displacement exists, and all our efforts to retain the uterus in place, after the artificial support is removed, will prove futile. I think I am not stating the proposition stronger than the experience of the profession will justify, when I say that no one of the text-books or any of the current literature of the day claim any method of *radical cure*, in this class named. In America, Thomas and Emmet have done much to popularize the use of pessaries, and many other

[1] Read before the Obstetrical Section of the International Congress at Copenhagen.

men have aided in giving them their deserved credit, yet no one of them claims for this class of cases radical cure. Relief follows, but once the artificial means are given up, the displacement returns. Schroeder, in speaking of certain forms of displacements, says, "but we must ever keep the fact in mind that in the majority of these cases the displacement as such does not admit of a permanent cure." The essential elements, in the lesions alluded to, which prevent a satisfactory result are: 1st, hyperplasia of the uterus and vagina, and 2d, a lacerated cervix or perineum, and in many cases both. These accidents, occurring at parturition, are ordinarily the cause of the arrest of involution, so that we have an extremely large and heavy uterus and capacious vagina, with the walls entirely separated, and the canal constantly open, from loss of power of the sphincter vaginæ and loss of perineal support, with flatulency of the vagina as an almost constant symptom.

In proportion as these accidents are greater or less, we have all degrees of displacement, either backward, forward or downward—generally the former and latter. An attempt to make a radical cure in this class of cases, without first removing these two conditions, will surely fail. Either being eliminated will not suffice. The uterus must be made smaller and lighter, the vagina must be shortened and narrowed, and the walls be brought in apposition. The various means for reduction of hyperplasia of the uterus that have been employed, it would be inappropriate to introduce into a paper like this, on this occasion; but from the days of Bennett who believed its pathology to be inflammation, to the modern and, as I believe, more rational view taught by Thomas, that of subinvolution, the practice has been substantially, depletion by local blood-letting and glycerin, and the use of cautery, caustics, escharotics, iodine, etc., etc. Added to this, Dr. Emmet introduced an important element to the profession in the frequent and abundant use of very hot water douches. In my opinion the principal value of this was and is in relieving the chronic passive congestion, and promoting absorption of the exudate consequent upon the previous attacks of inflammation. Various operative procedures were instituted by Thomas, who excised a small portion of the cervix, and by Martin, of Berlin, and

Schroeder, who made what they denominate amputation of the cervix.

Emmet made an important step in advance when he discovered that, what had so long been considered ulceration was really ectropion of the cervical canal, with granular degeneration, and made trachelorrhaphy; to do which, it became necessary to remove all the cicatricial tissue and unite the healthy parenchyma, and thus set up a process of fatty degeneration and absorption, that resulted in a more complete involution. We knew before that excising a portion of the hypertrophied tonsil induced this process, but it was reserved for the genius of Emmet to apply it to this condition, practically for the laceration, but the involution followed as a necessary consequence. This is a step to be taken wherever the laceration exists and taken first. But there are a large number in the class we are treating of, in which laceration is not an element to be considered, for it does not exist. The uterus is oftentimes enormously enlarged and almost cartilaginous. For these cases I make the following operation: I remove from each side of the cervix a V-shaped portion, cutting through the entire parenchyma from the os uteri upward, making the angle at a point as high as the vaginal junction, taking care not to open into the peritoneum. At this point considerable hemorrhage may follow the cutting, but if at all troublesome, we can easily control it by passing the superior suture directly through the vessel, which can be easily seen. The operation is best performed by long-bladed sharp scissors, curved on the flat. One stroke of the scissors should divide the half of each side with the exception of the angle which should be clearly and carefully trimmed, so that the edges shall be symmetrical. Now, if I design making both the uterine and vaginal operation, I use the catgut suture, which I tie in three knots to prevent slipping. Having put in all that are necessary to place the edges in complete apposition, without strangulating them, I replace the uterus, adjust a well-fitting pessary and proceed to make the operation upon the perineum and vagina. The only caution I would enjoin in this portion of the treatment, is, to be sure and denude the vagina high up in the centre, at least a little beyond the crest of the rectocele (if one exists). I would also caution against denuding too high on the sides of the vulva, lest we close the intro-

itus vaginæ and interfere with the sexual relation. Each suture should embrace its own amount of denuded tissue and be buried in the recto-vaginal septum, until we come to the last, which should be brought out at or near the centre, and then passed through the mucous membrane above, at one or two points, in order to bring down the posterior wall, and in this way to shorten that wall by the amount of the denudation. It is practically an amputation of so much of the mucous membrane, aside from the effect it produces upon the process of involution. In this way we convert a rectocele into the normal curve of the posterior wall, unite the separated ends of the sphincter vaginæ muscles and bring the walls in their normal relation, in apposition, and shut in the uterus supported by the pessary. Everything can now remain a sufficient length of time to restore the circulation to its normal condition, to allow the process of involution to begin, with an assurance that it will be completed without any further displacement. There is no occasion for disturbance of the pessary for a long time, therefore the perineum will remain intact. Without having a pessary there, the uterus becomes displaced, and we often attempt to replace and adjust a pessary while the perineum is yet sensitive and weak. During the entire operation I keep a constant application of very hot water by sponges and douche. The time for removal of the pessary will depend much upon the character of the case. In some cases only a very short time, in others much longer, and even changing for shorter and especially narrower ones; but with much care for a few months, we will find in a great majority of cases we can dispense with them altogether, involution of both uterus and vagina having taken place. I believe that far too much time has been lost, in this class of cases, in keeping the patient on what is called "preparatory treatment." The condition existing in a large portion of them, is one of chronic passive congestion and not of chronic inflammation. The latter term is, in my opinion, a misnomer, and leads to false conclusions in therapeutics. "Heat, pain, redness, and swelling" are not necessarily confined to inflammation, but are found in chronic passive congestion, and are relieved by the operative measures instituted. They exist on account of the displacement, and exudate from attacks of inflammation, and the fact that either pain or heat exist

in the pelvis does not contra-indicate operative measures as inflammation would. I therefore advise the operation as the best means of relief, unless it can be shown by well-marked symptoms that an attack of inflammation, which lasts but a few days, is actually present. The hemorrhage is the best relief to the tenderness and exudate.

The merits of the above operation upon the uterus, over any other proposed, are, in my opinion, 1st, a much more rapid change in the entire uterus, inasmuch as it extends up into the neck farther and affects more of the substance. 2d, it leaves the organ more symmetrical. 3d, the advantage of using catgut sutures and putting the womb safely in place with the pessary. 4th, obviating the necessity of interfering with the parts for several weeks. 5th, allowing the patient to move about earlier and receive the benefit of out-door air and exercise, and lastly, operating upon the vagina at the same time, we have uniformity in the process of involution in each organ.

The bowels and bladder should be allowed to act at will—avoid catheterization if possible. Move the bowels in a very few days if they do not act for themselves. Keep the parts thoroughly cleansed by warm water injections frequently repeated, feed the patient well, and give her the full benefit of rest and good care in every respect.