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SUSPENSION OF THE UTERUS.

THE OPERATIVE TREATMENT OF RETROFLEXION BASED ON A CONSIDERATION OF 200 CASES.

At the meeting of the AMERICAN MEDICAL ASSOCIATION in Baltimore in May, 1895, I made an address before the Obstetrical and Gynecological Section on the subject of the "Operative Treatment of Retroflexion," taking as a basis of my remarks the 170 cases upon which I had operated since coming to Baltimore six years ago. Since May I have added thirty more cases, bringing the total up to exactly 200. All but a few of these cases were operated upon in the Johns Hopkins Hospital; the others were patients in my private Sanatorium.

The mortality in the 200 cases has been zero, and there has not been a case of serious illness following the operation. There has been one recurrence of the retroposition, making the failures one-half of one per cent. In about 5 per cent. of the cases stitch-hole abscesses and separation of the lower angle of the incision occurred; this accident very rarely happens now with my present technique in closing the abdominal incision.

The suspensory operation was abandoned in one case recently because the enlarged uterus was so friable that the stitches cut out as soon as they were tied.

In all cases where the vaginal outlet was relaxed, it was repaired at the same time the uterus was suspended; when there is both retroflexion and relaxation of the vaginal outlet, if I can do only one operation, I prefer to lift up the outlet under the pubic arch. It is well known that I have always been an earnest advocate of the direct method of

treating retroflexion by a small abdominal incision, bringing the uterus into anteposition and holding it there by two stitches through the anterior abdominal wall and the posterior surface of the fundus. I am influenced by four principal reasons in concontinuing this method of treatment, which I originated nine years ago; these are:

a. A natural tendency to continue an investigation in the line already opened up (see *American Journal of Obstetrics*, January, 1887).

b. The advantages of a direct inspection of the ovaries and tubes, as shown by the cases of inflammatory adhesions found at the operation, where it was not known that any had existed. In one case I was fortunate enough to find a little papilloma, not as big as the end of my finger, starting out of the ovary. When the uterus is adherent no other method can be so good, as this is the most direct way of dealing with the adhesions.

c. The mechanical advantages of my suspensory operation acting directly on the posterior surface of the retroflexed fundus, are better than if the organ were held forward by pulling on the round ligaments of both sides.

d. Probably the best reason of all is the remarkable statistics of my 200 cases, without a single death, and with but one recurrence of the displacement in a patient in whom a tube and ovary were removed at the same time.

With this introductory statement I present my address substantially as given at the Music Hall last May, with the analysis of the first 170 cases. The last thirty are more recent and may, therefore, be left out without disadvantage.

I hope the illustrations which accompany my paper will help make clear some points which are difficult to describe away from the actual demonstration on the patient.

I have adopted the name "Suspension of the Uterus" as more correct than "Hysterorrhapy," which is a plas-

tic suture of the uterus, or than "Ventrofixation" or "Hysteropexy," both of which, though widely used, give a false impression of the results obtained. If the operation is properly performed the fixation (*pexy*) of the uterus lasts but a short time, after which the organ is found mobile with fundus well forward in an easy natural anteflexion, and with a marked space between it and the abdominal wall to which it was attached.

The cases forming the basis of this report are all of my operations between Oct. 16, 1889, and May 1, 1895, and they include all the cases I have ever operated upon by the method I shall here describe as the best.

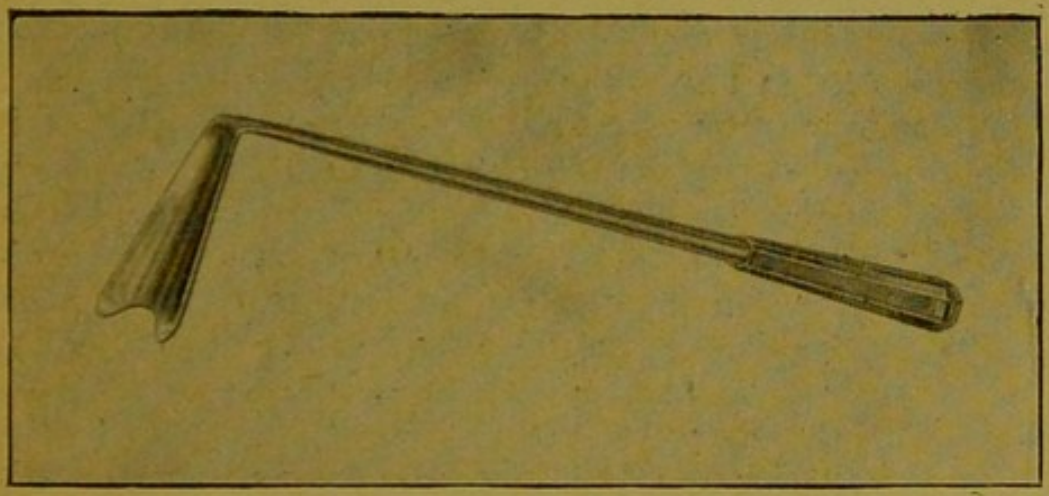

FIG. 1.—Elevator which serves to hold uterus up while first stitch is being passed.

In my earliest efforts to hold up the retroflexed uterus in anteposition, I utilized first the cornu uteri and then the anterior face of the broad ligaments, taking by preference the round ligaments close to the uterine attachment, as recommended by Olshausen.

Most of these cases held well, but some eventually dropped back and the old symptoms returned. The reason for this (as I pointed out in my first paper in the *American Journal of Obstetrics*, Jan. 1887, p. 33), is clearly that the uterus is put in a position of mechanical disadvantage when the anterior face is drawn

up against the abdominal wall above the symphysis.

The result of my experience is that the best way to do the operation is to bring the uterus into anteflexion by passing the sutures through its posterior surface. In this position a slight force will hold it better than a much larger one where the fundus is thrown back by bringing the anterior face against the abdominal wall.

Indications for Suspension.—The indications for suspension of the uterus are the existence of a retroflexion which cannot be corrected, or whose symptoms can not be relieved by non-operative treatment, such as packing, massage, and pessaries.

I would use it in all those cases of retroflexion which, as Dr. Beverly MacMonagle of San Francisco puts it, are more or less tied to the office of the physician by their ailment; patients who may go for years, better at times and then worse again for several weeks or more, and never feeling quite well.

I would also urge a suspension where the menstrual difficulties, backache and bearing down pains, headache, loss of appetite, difficult defecation, and various general disturbances are persistent.

The classes just cited are easily recognized because their pelvic symptoms are so prominent as to attract attention at once; but there is another class of neurasthenics equally important, whose local symptoms may be more or less in abeyance, and where the first impression is that the neurotic condition is primary and fundamental, and the local disturbance merely accidental. I know of no class of cases where a good professional instinct and good judgment come into better play in selecting the suitable case and rejecting the others.

In a woman who is persistently neurasthenic, or in one who after repeated building-up efforts persistently falls back into a morbid nervous state, where there is a retroflexion or retroposition, with definite pelvic disturbances becoming more marked at the menstrual period, I would without hesitation urge suspension.

A young woman came under my care three years ago, through the courtesy of Dr. I. E. Atkinson of this city. She had been bed-ridden for four years, most of which time she had spent in a hydropathic establishment securing imaginary improvements. She was a typical hysterical neurasthenic, as she lay drawn up in bed, with a miserable pinched look, ap-

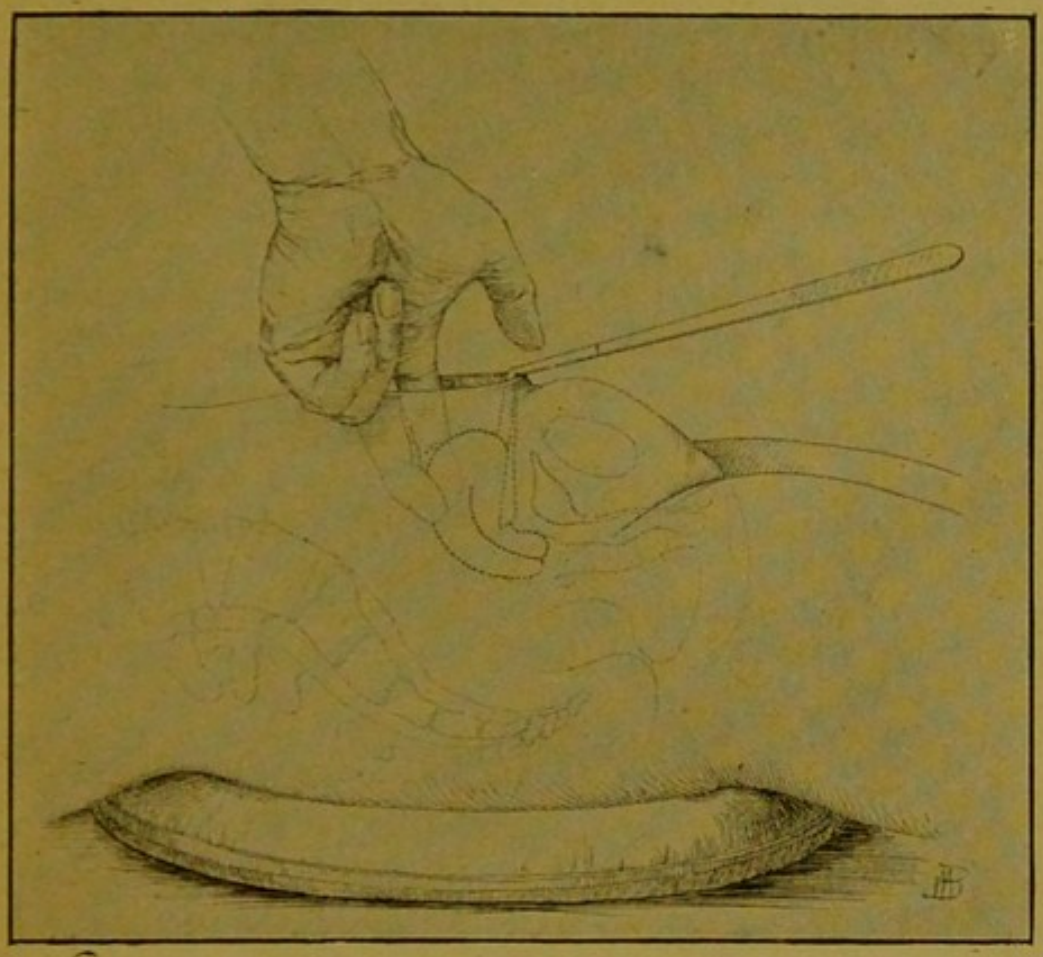

FIG. 2.—Elevator in and hand holding uterus in place while first stitch is passed through posterior surface of fundus.

parently oblivious, but really taking in all that was going on about her.

She had that peculiar expression which is so easily read and which forbids any appeal to reason and high moral grounds as out of the question. The only tangible trouble was a retroflexion, with tenderness and marked disturbances at each monthly period.

I first shortened both round ligaments intraperitoneally by Wylie's method, and she began to improve in a remarkable manner, but one day about three weeks after the operation I found her again miserable and depressed, complaining of all her old symptoms. Examination showed that the uterus had dropped back to its original position. The abdomen was reopened and the uterus suspended by my present method. She at once got better and is to-day one of the finest and healthiest women mentally and physically that I have the pleasure of counting among my friends. I have never seen a greater transformation in any one. I should therefore operate for a retroflexion in the hysterical, neurasthenic patient with pronounced pelvic symptoms, but I should do it with the expectation of an occasional failure to give relief. One cure like that above is worth even half a dozen failures, provided they entail no disability upon the patients.

Operation.—The method of operation is as follows:

1. After due preparation, emptying the bladder and anesthesia, the abdomen is slightly elevated and an incision 3 to 5 cm. long is made down into the abdominal cavity, beginning about 2 cm. above the symphysis.

2. The peritoneum is then caught with artery forceps on each side and drawn out. This is to prevent the pulling in of the peritoneum by the suspensory sutures and so leaving none to close the incision.

3. The retroflexed uterus is then hooked up and lifted into anteflexion by means of two fingers carried into the wound.

4. One side of the incision is then elevated with two fingers, and the peritoneum and subperitoneal fascia caught with a curved needle carrying the suspensory silk ligatures. The amount of tissue embraced is about one-third of an inch wide and one eighth of an inch in depth.

5. The same ligature is then conducted through the uterus on its posterior face below the fundus, and

finally through the peritoneum and fascia of the opposite side, when it is tied, bringing the uterus up snugly against the anterior abdominal wall. If the pelvis is deep and the uterus lies out of reach, it may be brought up and held in position while passing the suture, by means of an elevator such as is shown in

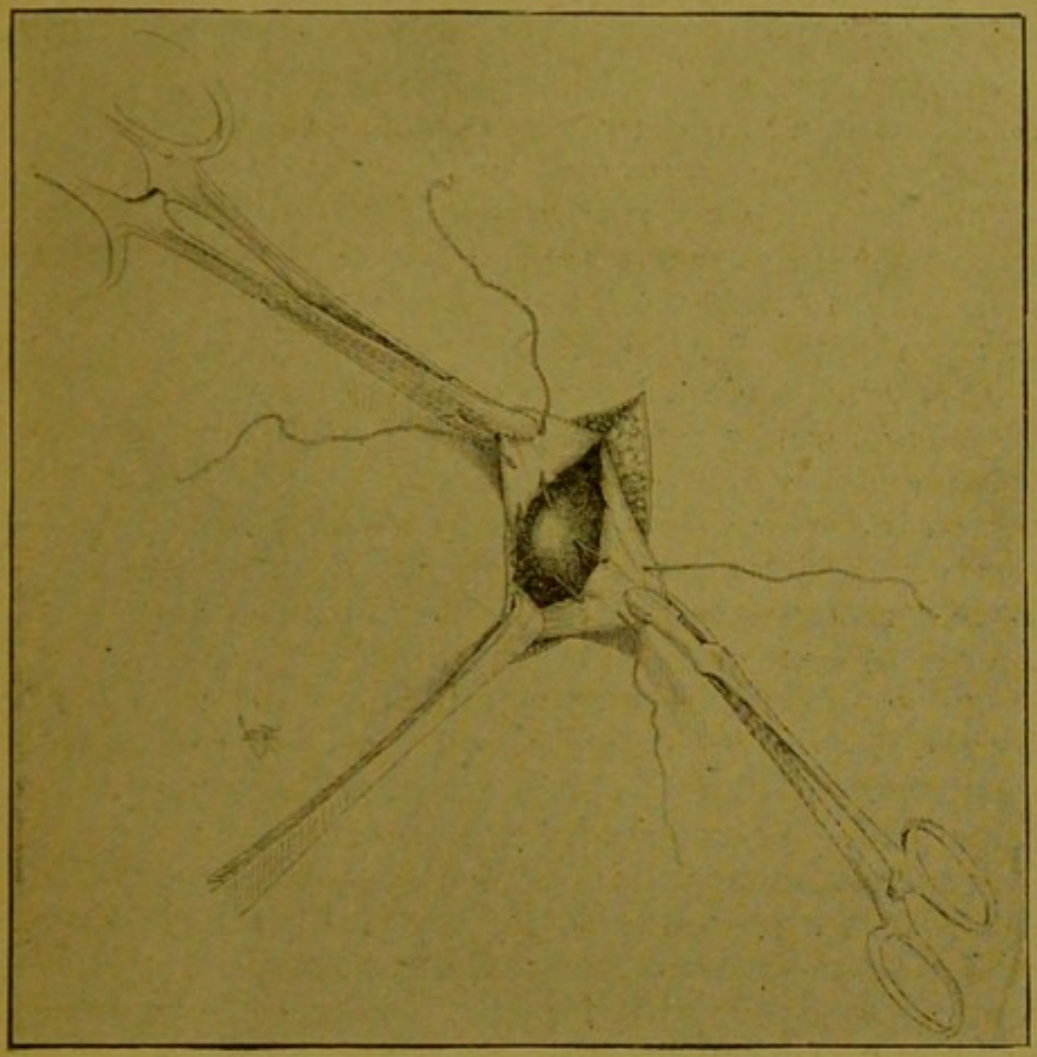

FIG. 3.—Two silk sutures in place in the posterior surface of uterus near fundus, not yet tied.

Fig. 1. This is introduced down into the pelvis in front of the uterus, which is pressed into it and held as against an artificial symphysis. As soon as the first stitch is passed the elevator is laid aside. After tying the first suspension suture, the second is easily put in, entering and emerging on the abdominal wall

just above the first and piercing the posterior surface of the uterus just below the first; when this suture is tied, it increases the anteflexion.

6. The sides and front of the uterus are then examined to see that no intestine is caught, and the omentum is drawn down, and

7. The abdomen is closed. I do this by taking off the forceps and sewing up first the peritoneum with the finest silk, and then drawing together the fascia with one or two silver wire mattress sutures, finally closing the skin with a subcuticular suture of fine silk.

The patient may rise sooner, but I find it better to keep her quiet from two to three weeks. It is not necessary to wear an abdominal bandage, and I never put in a pessary afterward.

It was necessary in one case to reopen the abdomen for a hemorrhage following the operation; this arose from the slipping of the ligature at the cornu uteri, where there was the stump of an amputated tube and ovary. There was no trouble from adhesions or the incarceration of a knuckle of intestine in front of the uterus in any case.

Out of 130 of these cases carefully analyzed for me by Dr. George W. Edwards within a few weeks of the operation, 100 were reported well, 26 improved, 4 not improved. The recovery was interrupted:

By a transient mania in 3 cases; by bronchitis in 3 cases; by pneumonia in 1 case; by stitch abscess in 3 cases: by hemorrhage from a repaired outlet in 1 case; by dysuria in 4 cases; by hysteria in 4 cases.

The proportion between married and single women was about 2 to 1.

I am not prepared at present to state the number of children born since operation. There have been at least six pregnancies, and in but one was there any marked discomfort and dragging due to the attachments of the womb. (*Amer. Jour. of Obs.* 1894, p. 370.)

I do not know of any case in which the retroflexion has recurred after pregnancy.

There has never been a hernia in any case.

In women who have borne children the retroflexion is often associated with descensus and relaxation of the vaginal outlet. It is useless to expect relief in these cases by simply suspending the uterus which, instead of being gently detained in easy anteflexion, simply drags on its attachments until they give way. In such cases the vaginal outlet must invariably be repaired too. Sixteen out of 133 cases needed the vaginal repair. In going over my statistics I am surprised to find so few needing the double operation, for I am sure that the percentage is much larger in the recent cases.

In 7 cases both tubes and ovaries were removed for disease; in 9 cases one tube and ovary removed; in 3 instances I ligated either uterine or ovarian vessels; in 2 a myomectomy was performed; in 1 a nephropexy.