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BY

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WITH A WOODCUT.

LONDON:
H. K. LEWIS, 136 GOWER STREET, W.C.
1878.

PRINTED BY H. K. LEWIS, 136 GOWER STREET, LONDON.

ON THE USE AND ABUSE OF PESSARIES.

So various are the views held as to the value of mechanical appliances in the treatment of uterine deviations, that while, on the one hand, many eminent gynæcologists regard pessaries with great favour, as very efficient aids in the treatment of deviations and the morbid conditions so frequently associated with, if not actually dependent on, them, others, equally eminent, are as much opposed to them, attributing to their use untold mischief.

At the Manchester meeting of the British Medical Association Dr. Braxton Hicks read a paper "On Hæmorrhage from the Retroflected Uterus, and its Treatment," in which he urged that the weighty and engorged fundus uteri was most relieved by mechanical support, at the same time combating the objections to this mode of treatment, and he quoted a case in illustration. At the same meeting Dr. Thos. Chambers read a paper "On the Treatment of Uterine Flexions by the Intra-uterine Stem, with Cases." Dr. Henry Bennet "felt bound to state that his whole experience was antagonistic to the doctrines and treatment recorded in the paper read." Dr. Matthews Duncan agreed with Dr. Bennet, adding that "there was a fashion in these matters. Years ago every woman suffering from uterine disease was said to have a dislo-

cated uterus; at a later period no one had any affection of that sort; and now, once more, every woman was getting her uterus dislocated again, and he defied all the doctors in Christendom to put it right." This is the report furnished by the *Journal*, and I presume it has met with Dr. Duncan's approval. Now to quote such exaggerated misrepresentation is to refute it.

This might suffice, but I shall return to the subject.

During a discussion at the Gynæcological Society of New York, Dr. Atlee, of Philadelphia, observed that he had had no experience in the *introduction of pessaries*, but that he had had a large experience in their withdrawal. He had been able to remove the symptoms in most of his patients without the use of pessaries, and when that could be done he was satisfied without their use. With the *uterus and pelvic organs in a healthy condition* a change in the position of the uterus was of no significance whatever, and there was no need of an instrument to keep it in a certain position. (The italics are mine.) Now, when Dr. Atlee tells us that he has had no experience in the introduction of pessaries, he at once puts himself out of court, and when he states that he has been able to remove the symptoms in most of his patients without the use of pessaries the obvious reply is that if he had used the pessary in the rebellious cases still greater success would have attended his treatment. Again,

when he says that with the uterus and pelvic organs in a healthy condition (and I would add *and the patient free from symptoms*) a change in the position of the organ is of no significance whatever, he states a self-evident proposition. I have taken part in frequent discussions on this subject, and I am unable to recall a single instance of any one contesting this point. For what is the object of all treatment? It is *to relieve symptoms*, and the relief of symptoms is the measure of the efficacy of all treatment. A man with a dislocated shoulder, which does not interfere with the full use of his arm, would not trouble himself about reduction any more than a woman with a dislocated uterus, which produces no symptoms, would apply for relief. Is it nothing to be able to say that a woman who walks into your consulting-room, complaining of pain in the sacral region, and an undefined feeling of "bearing down" in the pelvis, which interferes with her walking, is aggravated by a fæcal evacuation, and prohibits sexual relations, in a few minutes after the application of a pessary, walks with comfort, tells you she is now free from pain, and goes home to find that she can discharge all her duties with satisfaction? Can the same be said of any other method of treatment —the frequent rectifications of the uterus by means of the sound, or by the fingers, the repeated scarifications and leechings, and the two or three years' treatment of Dr. Henry Bennet?

I return to Dr. Matthews Duncan. When he says that, "years ago every woman suffering from uterine disease was said to have a dislocated uterus," I ask for the proof. Nor am I old enough to have any remembrance of that "later period" during which "no one had any affection of that sort." But I *know* it to be untrue that "now, once more, every woman is getting her uterus dislocated again." For what does this statement amount to? It amounts to a charge either of gross ignorance or wilful misrepresentation on the part of many men whose abilities and merit are equally recognised. Not content with this general condemnation of his fellow practitioners he goes further and defies all Christendom to remedy a dislocation. I accept this challenge and place in the forefront a case of which Dr. Matthews Duncan had *some* knowledge.*

* In a letter to the *Lancet* of Feb. 2nd, Dr. Matthews Duncan disclaims the attaching of any importance to what he calls "a casual statement." It is my duty to call attention to the fact that this casual statement was made before an assembly of representative men who did not attach so little importance to his words. One gentleman thought "the words should be written in gold." This was in Dr. Matthews Duncan's hearing and then was the time to disclaim their importance. Dr. Duncan further says, "he thinks the support by a Hodge or similar vaginal pessary, of a large, tender, displaced uterus, a plan of treatment well worthy of trial." One would have expected a more definite statement than that it is "*worthy of trial.*"

Case 1.—About seven years ago I was asked by a friend to see his wife, who for months had been almost confined to her bed. She had had two children, and had never been well since her last confinement. I was told that she had been for several months under medical treatment, but without any benefit: that the use of a pessary had been suggested, but that the proposition had met with no favour. On examination I found the uterus very large, measuring about three inches and a half in its cavity, and so retroverted that the os uteri pointed to the upper part of the vaginal outlet. The left ovary could be felt most distinctly prolapsed into the left side of the utero-rectal cul de sac, and it was very tender to the touch. The right could also be felt by bimanual examination scarcely lower than its normal position. I was also told that for many months the patient did little more than pass from her bedroom, usually in the evening, to the couch in the sitting-room, so much pain did the erect position, or the act of walking, cause her. There was no leucorrhœa nor excoriation, nor could I find any cause for the symptoms other than the retroversion of the uterus and the consequent prolapsus of the ovary. I at once replaced the uterus by means of the sound, and, while it was thus kept in position, introduced a Hodge's pessary. The sound indicated that the pessary was not efficient. I therefore removed it, and passed a larger instrument,

with satisfactory result. The ovary was no longer prolapsed. I asked her to get out of bed while we left the room. This she did with a sense of great relief, and I bade her good-bye, recommending her not to exert herself much for a few days. I remained a short time in the house in conversation with her husband, and before leaving had the satisfaction of seeing her walk into the room, when she expressed her delight at the success of the treatment. Beyond this nothing was done except the administering of an occasional dose of a saline chalybeate aperient. The patient came to my house two or three times (a distance of four miles) in order that I might be satisfied as to her condition. After several months the instrument was removed, the uterus and ovary were left in normal position, and the patient has continued quite well to this day. The question naturally arises, why did her former attendant, a man of great fame and experience, afford this patient no relief? And the answer comes, that either he failed to recognise the existence of a "dislocated uterus" and ovary, or was not aware of the value of the pessary.

Case II.—*Retroversion with menorrhagia.*—In 1871 Mrs. B—— came under my care suffering from severe menorrhagia and dysmenorrhœa for which she had been under medical treatment for several months. She complained of constant pain more or less severe, which so interfered with her walking that it was with great pain and difficulty she made

her way to the out-patient department of the Samaritan Free Hospital. Menstruation was excessive in quantity and duration. I found the uterus very much retroverted, body enlarged, cavity measuring about $3\frac{3}{4}$ inches. The organ was readily replaced by means of the sound, but at once fell back on removing the support. There was tenderness of the body on pressure, great tenderness of the fundus on pressing the sound against it, and a little blood followed the use of the instrument. I at once adjusted a Hodge's pessary with my usual precautions, and the patient went home in great comfort with a prescription for tincture of muriate of iron and liquid extract of ergot, ten minims of each to be taken three times daily. From this time I attended the patient at her own home. She wore the instrument for about nine months, during which time she was able to attend to her household duties; the periods gradually assumed the normal character, assisted, as I believe, by the use of two sponge-tents, and I removed the instrument. This patient is still quite well.

Case III. — *Retroversion; severe menorrhagia; Hodge's pessary; subsequent pregnancy.* — Mrs. D——, aged thirty-three, came under my care at the Samaritan Free Hospital in the summer of 1875, the subject of severe menorrhagia, which told its tale in her anæmic appearance, and from which she had suffered since her last (sixth) child

about a year and a half ago. She also complained of a constant bearing down, and stated that the loss of blood was very great, and she was scarcely a week free from a hæmorrhagic discharge. I prescribed iron and ergot. A few days afterwards I was requested to visit her at her own home, and so great was the loss that I at first thought I had to do with a case of abortion. I then found the uterus very much retroverted, and prescribed ten grains of gallic acid every two hours. As soon as possible I admitted her into the hospital, and on the same day adjusted a Hodge's pessary. This gave immediate relief to the feeling of bearing down. I kept her in bed for about a fortnight, administering iron and ergot three times a day, with the result of procuring her an interval of nearly three weeks and a moderate period. I then dismissed her. She returned on Nov. 9th, stating that the menses were regular and not excessive in quantity, the flow lasting eight days "off and on." She complained of some discomfort in the left groin. Uterus found in good position, well supported by the pessary. The bowels were constipated, and she had frequent headaches. I prescribed quinine and iron and a mild aperient every night. On Dec. 7th I substituted for this a saline chalybeate aperient, with such effect that by Jan. 25th, 1876, she was again free from symptoms. The last period continued for seven days, and was fair in quantity. After an interval of three weeks,

viz., on Feb. 11th, she again returned, complaining of aching in the pelvic region and bearing down, and stated that she had "gone over her time." I kept her under observation till May 2nd, when I was satisfied that she was pregnant, and on the 23rd I removed the instrument. She was confined on Sept. 25th. No return of the retroversion or menorrhagia.

CASE IV.—*Frequent abortions, due to retroversion; menorrhagia; Hodge's pessary; subsequent pregnancy.* Mrs. H——, aged twenty-four, married eighteen months, consulted me on Oct. 9th, 1872, on account of menorrhagia and frequent miscarriages, of which she had had three—the first at three months, the second at four months, and the third at two months. She complained of a feeling of weight in the sacrum and hypogastrium, increased by exertion. Menses very free, lasting eight days, much more abundant than before marriage. Patient, moreover, was anæmic in appearance. Uterus retroverted; os open: uterine tissues generally flabby; slight leucorrhœa. A Hodge's pessary kept the uterus in excellent position; iron and ergot prescribed—Nov. 9th; Uterus in good position, admitting sound readily in normal direction. I recommended her to continue the treatment, and to let me know should she miss a period. —Jan. 8th, 1873: Stated that she had last menstruated in the last week in November, and for the last few days had felt sick in the morning. For

the last few days she had felt some bearing down on standing. I found the pessary lying across the vagina, but the uterus still in position. I withdrew the instrument, and while the patient was in the knee-shoulder position I re-introduced it.—It will suffice to say that on Jan. 26th she had a slight hæmorrhagic discharge; that on Feb. 10th I substituted (with immediate relief to pain in the sacral region on sitting or standing) a larger instrument, as the uterus was rather low in the pelvis; that from the 24th to the 27th she was again threatened with abortion; that I removed the instrument on May 22nd, and that the patient was confined on Sept. 3rd, under the care of Dr. Baxter Forman, of Stoke Newington. She made a good recovery, has had more children since, and is now, I believe, in good health.

Case v.—*Retroversion, with attendant symptoms; pessary; pregnancy.*—Mrs. S——, aged twenty-seven; six children, the last on Sept. 20th, 1875. She came under my care on April 3rd, 1876, stating that since her last confinement she had suffered from severe bearing down and pain in the hypogastrium, for which she had been continuously under treatment, but without relief. Bowels costive and evacuations painful; sexual relations intolerable. I found the uterus retroverted, the fundus and body tender on pressure (with the view of elevation by the finger), and the os open, admitting the tip of the index finger; no excoriation and

very little leucorrhœa. A Hodge's pessary gave immediate relief, and the patient walked home in comfort. I prescribed also a saline chalybeate aperient. On the 5th she returned to say that she was perfectly free from pain in walking, and had no bearing down. On July 1st I removed the pessary as an experiment, though the time was in my opinion too short; but the uterus remained in good position. She returned on the 8th, with the uterus again retroverted and a recurrence of the old symptoms. I re-introduced Hodge's pessary, with the same result as before. On Sept. 18th the sound entered readily in the normal direction, and there were no symptoms. Nov. 14th: Had missed her period by four days, and for several days had had morning sickness. On March 19th, 1876, I removed the pessary; and on July 20th I attended the patient in her confinement, from which she made an excellent recovery. No return of the retroversion.

Case VI.—Mrs. S——, the subject of repeated miscarriages, was sent to me by a neighbouring practitioner, by whom she was supposed (from her symptoms) to be suffering from prolapsus. The case was one of retroversion, and was at once relieved by a Hodge's pessary. About a month afterwards, through violent exertion in lifting, the instrument was thrust out, and her old symptoms returned. I re-introduced the pessary. She became pregnant some months after. The instru-

ment was worn till about the fifth month, and the patient was somewhat prematurely delivered of a double monster, which is now in the museum of the Obstetrical Society.

I could go on repeating cases *usque ad nauseam* to show the great value of this instrument in cases of retroversion. As I stated at the Manchester meeting, I regard it as a most efficient aid in the cases treated of by Dr. Braxton Hicks, and in many cases as the only treatment necessary. The preceding cases show in the clearest manner the direct relation between the displacement and the attendant symptoms. It is, moreover, with me a matter of repeated observation that in cases of subinvolution complicated with retroversion, the restoration of the uterus is a *sine quâ non* of successful treatment. Common sense teaches, and experience confirms, it. Of course medical treatment goes hand in hand with the mechanical, but only according to circumstances. Each case must be a law to itself, and it is impossible to lay down such rules as will do away with the necessity for the exercise of common sense. It is true we sometimes, but very rarely, find cases of retroversion in which no symptoms are attributable to the displacement, but this fact can hardly be used as an argument against the use of mechanical treatment in cases in which the symptoms are directly tracable to the displacement. On the other hand, the man who, on finding a uterus retroverted, at once

rushes to his stock of pessaries, and proceeds to use one as a *matter of course*, is not to be commended either for his judgment or skill.

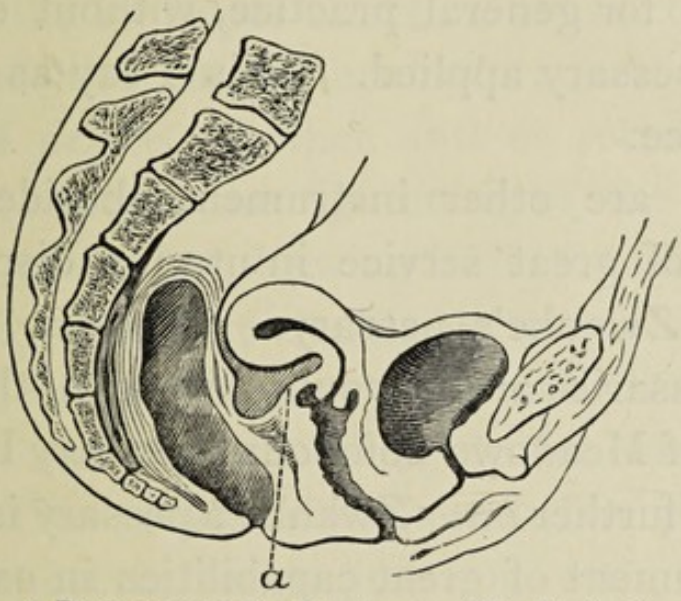
The mode of application of the pessary is, in my opinion, a most important matter. I regard it as essential that we should in all cases, if possible, obtain positive indications that the instrument is efficient. This is best done by placing the patient on her back, and maintaining the uterus in position by means of the sound until the pessary is in its place. If the sound retains its position when let go, then we know that the uterus is properly supported, while the slighest deviation at once tells us the reverse. Then the pessary must be removed, and its shape or size altered as required. I cannot agree with Dr. Braxton Hicks that it is of no consequence that the uterus should at once be accurately replaced. He thinks we should be satisfied with a partial adjustment, leaving the accurate replacement for a future opportunity. Theoretically at least this is strange teaching, and is not in keeping with his usual scientific precision. My experience is decidedly opposed to it, for in proportion to the failure in accurate replacement is the want of success in relieving the symptoms.

Difference of opinion exists as to the mode of action of Hodge's pessary. For while some hold that the support is directed through the fundus, others regard it as the result of action on the cervix. I accept the latter view in the great

majority of cases, for my best results have been obtained with the long **S**-shaped instrument (I am here speaking of *retroversion*). It is undeniable that in some cases the posterior cul-de-sac of the vagina is so large and distensible that it is possible to afford support through the fundus; but the cases are so rare as to constitute the exception which proves the rule. I have repeatedly demonstrated in the out-patient department of the Samaritan Free Hospital that backward pressure on the cervix brings the uterus forwards, especially when aided by a suitable position, such as the knee-shoulder position, and in cases of pregnancy I have taken advantage of this fact in adjusting or readjusting a pessary. This results also from the fact that the uterus is a rigid body (in cases of *version*). This pessary, then, acts in the first place by stretching the vagina longitudinally. The result of this is that the posterior cul-de-sac is tightened, the cervix is drawn backwards, and the body moves proportionately.* The neces-

* That the direction of the uterus can be altered by traction on the cervix through the vaginal wall in cases of version is very readily demonstrated by using Neugebauer's speculum in a case of well-marked anteversion. Every one knows how difficult it is to get the os fully into view when using Ferguson's speculum, and that it is always necessary to fix and hold the uterus by means of a tenaculum or vulsellum forceps. In the use of Neugebauer's speculum, separation of the two blades, by approximation of the handles, brings the os full into view, as thoroughly as if held by forceps. It can also be demonstrated that the same act will retrovert a uterus from its normal position.

sity of having an accurately proportioned pessary must be at once apparent, and this is well illustrated by the first case I have quoted. Moreover, a consideration of the anatomical relations of the parts leads us to the same conclusion. If anyone will take the trouble to look at, say, Savage's Plate VIII., Fig. 2, or Plate XI., Fig. 3, he will at once see how impossible it is, in any ordinary case, to bring pressure to bear on the fundus. Here is a dia-



a Peritoneo-vaginal septum. (Dr. Junker).

gram, for which I am indebted to Dr. Junker, illustrating the condition of retroflexion, which speaks for itself. A pessary acting by its posterior transverse bar on the peritoneo-vaginal septum at *a*, forces it backwards and upwards, until by a good deal of stretching it perhaps reaches the fundus. At the same time it drags the cervix in the same direction, with the effect of still further doubling the uterus, except in so far as it is obviated by a rotation movement of

the latter. Hence, as I shall show, the uselessness of vaginal pessaries in cases of *retroflexion*.

The evidence as to the value of Hodge's pessary, in all its modifications, is overwhelming, and it is now too late to take refuge in systematic pooh-poohing. And while it is capable of doing much good in skilful hands, it must not be forgotten that it is equally capable of much injury in the hands of the ignorant or careless. I am afraid it is a fact that many men pass through our medical schools, destined for general practice, without ever having seen a pessary applied. This I say as a result of experience.

There are other instruments besides Hodge's pessary of great service in uterine displacements, notably Zwanke's pessary. The flat ovoid box-wood pessaries are, I would fain hope, things of the past. Of Meadows' compound pessary I shall have to speak further on. Zwanke's pessary is, however, an instrument of great capabilities in cases of prolapsus in the young, and affords great comfort to the aged. The facility with which it can be applied and removed by the patient is a great recommendation. It is not infrequent among the poorer class for a woman to get prolapsus as the result of getting up too soon after confinement. The easier and shorter this is, the more likely is it to happen, both being dependent on the large size of the pelvis and the dilatability of the soft tissues. I have seen the uterus in such a case, measuring

four inches and a half, become reduced in three months to its normal size, and I have seen a similar case cured by a subsequent pregnancy, proper precautions being taken during the puerperal period.

The abuse of the pessary may arise from several causes, which may be enumerated as follows:—(1) Improper selection of cases, (2) use of an ill-fitting instrument, (3) misuse of a properly-fitting instrument.

I. As to the improper selection of cases. In the front I place the employment of vaginal pessaries in cases of *flexion*, whether ante or retro. In the case of retroflexion, the tightening of the posterior cul-de-sac tends, by drawing back the cervix, as I have already shown, to double the uterus still more, and any effect produced on the body will simply be a rotating movement. What do we find at the bedside? The posterior transverse bar passes up behind the cervix to its junction with the body (which is the site of flexion); the tightening of the cul-de-sac drags the cervix still more backwards; the pessary slips into the hollow of the flexion, especially if the instrument be not straight; and the body of the uterus topples over, aggravating the previous condition. Let us assume that the pessary has been applied while the uterus is kept in position by means of the sound. If now the sound be left unsupported, it, slowly it may be, but surely, turns round until the body of the uterus

hangs over the transverse bar, behind which it can be felt by the finger. Let the sound be removed before the uterus has been allowed to fall back, and then let the sound be re-introduced, or rather, I should say, let the attempt be made, and I unhesitatingly affirm that failure will be the result. I have repeated this so often in deference to the generally received views that I have no doubt about the matter. The views I now hold are the result of the many failures I have experienced, and in proportion as I have acted on the knowledge thus obtained so have I been more successful. At a recent meeting of the Obstetrical Society, I took occasion to express my surprise that the advocates of the vaginal pessary in cases of *retroflexion* were still so numerous. In this I am not without supporters.

Nor in the case of anteflexion is the result much more satisfactory. Look at Dr. Graily Hewitt's Plate 78 (second edition), and it will be seen that the highest point of the instrument is just at the point of flexion. When the bladder is empty, what is there to prevent the uterine body from bending over the instrument? But, it may be argued, this pessary relieves the dysmenorrhœa. True, it does in some cases, where there is no contraction of the internal os, by converting a flexion into a version, by the action, already described, on the cervix. But where constriction exists, it only aggravates the dysmenorrhœa, as I have proved. Here, then,

is the case for an intra-uterine stem, either with or without previous division.*

There is another condition which I find nowhere described, but which I have several times observed, and in which no vaginal pessary yet devised could be of any service.

S. H——, aged twenty-three, single, came under my care in the out-patient department of the Samaritan Free Hospital on April 6th, 1875. Menstruation began at the age of sixteen, and for the first few years was not sufficiently painful to draw special attention to it. For the last ten months she complained of a constant bearing down in the hypogastrium, and pain in the left groin. The periods recurred with a clear interval of three weeks, and usually lasted four to five days. For a day or two before the flow she suffered from pain of a special character. For the first day of the flow the pain was especially severe. After that it gradually decreased, and finally ceased with the flow. There was a free glairy discharge, and there was marked congestion of the cervix. She also complained of frequent frontal headaches. Her

* In a letter to the Lancet of Feb. 9th, 1878, Dr. Graily Hewitt admits the justice of this criticism, and refers me to a speech of his at the meeting of the Obstetrical Society of London, on April 5th, 1876, in which he confessed that the instrument figured in his book had not answered his expectations, and that he had modified it so that the support was given at a higher point. I fail to see the improvement, for the reasons given in the text. It must be remembered that the bladder in its empty state is *below the level* of the fundus uteri.

appetite was tolerably good, and the bowels regular, but she had frequent attacks of what she called "spasms." On examination I found the hymen intact, and the vagina very small. The os uteri was directed against the anterior vaginal wall, and the cervix felt somewhat flattened. The body of the uterus could be felt through the posterior cul-de-sac for some distance, so that I at first thought I had before me a case of retroversion. Firm upward pressure in front of the cervix, however, revealed the presence of the fundus uteri there, and the finger detected the well-marked concavity formed by the anteflexion. Thus the uterus was anteflexed and retroverted at the same time, the body lying low down in the hollow of the sacrum. Backward pressure on the cervix caused the uterus to revolve, so that the fundus was more readily felt in contact with the back of the finger. Having observed this condition before, I now recognised the true nature of the case. The patient was contemplating marriage, and requested me to advise her. I had no hesitation in putting my veto on such a proceeding, being well aware of the injurious consequences of the married state in cases of anteflexion. I kept the patient under treatment for over three months—viz., till July 20th, with some relief to the general symptoms. The congestion was decidedly less, and the leucorrhœa had well-nigh ceased, but the deviation continued in no way altered. She returned on October 29th,

having relapsed into her former state, and, after a little persuasion, I got her to consent to the local treatment which I formerly proposed. She accordingly entered the hospital on Dec. 13th, just after a period. Next day I introduced, with great difficulty, and not until I had pulled the uterus straight, a fine laminaria tent. On the following day it was well dilated, and half extruded from the uterus. I gave her a day's rest, and on the 17th I introduced one of my stem pessaries without difficulty, and left the uterus in good position. On the 20th, as the patient was feeling uncomfortable, I again examined her, and found the uterus retroverted, so that the bulb of the stem was near the vaginal outlet. I then introduced a long S-shaped Hodge's pessary, apparently with the desired result, and the patient was relieved. On the 31st the patient got an attack of ulcerated sore-throat, with considerable fever, through which she passed satisfactorily. During this attack, be it remembered, she was wearing the two instruments. On Jan. 1st the menses appeared and disappeared on the 4th. All she felt was a little aching in the back. On the latter day I made the following additional note: "Patient now sitting up; no pain of any kind." Jan. 7th: Uterus a little inclined backwards and to the left side; no discomfort in any position. On the 8th she returned home. On Jan. 21st she again came to the hospital, where she was seen by Dr. Kuhn, of Geneva, who con-

firmed my diagnosis as to the existence of the slight displacement above mentioned.—Feb. 11th: Last period, after an interval of three weeks, and for about three days. No pain during the flow, but an aching and fulness in the groins for about a day before. Continues to follow her usual occupation in the Government Clothing Establishment, and is not conscious of the presence of the instruments.—March 10th: Menstruated again from 1st to 4th without pain; quantity moderate. The uterus being still in the same position, I took out the Hodge, made it nearly straight, and re-introduced it. At the end of a fortnight I removed both instruments.—April 29th: Uterus threatening to return to its old state. Introduced a Meadows' compound stem, which kept the uterus in admirable position. I, however, made the following note: "Probably too large."—May 3rd: Complaining of pain down the thighs, particularly the right. Substituted a smaller instrument, which produced no discomfort. I saw the patient several times up to August 10th, when I removed the pessary, leaving the uterus in very good position. Her general health was then very good, and her headaches had quite disappeared. I recommended her to get married without delay, and this was effected on the 18th of November. She menstruated regularly, with an interval of three weeks, *without pain of any kind*, and for the last time in the end of January, 1877. During her

pregnancy, which she expected to terminate at the end of September, she enjoyed most excellent health. Her own words are (referring to the latter months), "I was never better in my life." (This patient was delivered of a fine female child on Oct. 16th, 1877, and is now in excellent health.)

Nor is it advisable to employ a pessary during the existence of acute inflammatory action in the uterus. Acute symptoms should be first subdued by the usual methods according to circumstances.

Sometimes retroversion is complicated with a fibroid in the posterior wall, and in such a case the vaginal pessary is not well borne. In these the fibroid is of more consequence than the retroversion.

There are not a few cases of retroversion in which there is great difficulty in replacing the uterus, and this is usually attributed to adhesions within the peritoneal cavity. These do not, as a rule, bear the pessary, or if they do, the version is in no degree influenced. In fact, the most probable result is the conversion of a version into a flexion in the way already pointed out. I have, however, employed Meadows' compound stem in some of these cases with decided benefit. Such a case I have now under my care in the person of a young lady, who has been much relieved by it. In no case has any untoward result followed the use of this instrument. But they are unsatisfactory cases at the best.

2. There is no more frequent cause of failure in obtaining the full value of the pessary than in the "use of an ill-fitting instrument." It has frequently happened to me to find that the first instrument, after apparently being right when first introduced, has been inefficient. The test of this is the facility with which the sound can be introduced. It has also frequently occurred to me to have to remove pessaries introduced by others, and, had I not known the value of the instrument, I might have been induced to endorse the views of Drs. Bennet and Atlee. In these cases the removal of the instrument has been necessary because of both the improper size and shape. Sometimes, however, there can be no doubt the instrument becomes too small in consequence of the stretching of the vagina. I know this has happened in my own hands. Case 4 is an example.

The habit of employing hard vulcanite pessaries is apt to contribute to this misuse; they are not kept in sufficient variety, and are difficult to alter. I have now for some years been in the habit of using those made of pewter. They are obtainable from Krohne and Sesemann in nine sizes. They are light, easily altered, and produce no irritation. I have known these instruments worn continuously for over a year without undergoing any change; and they have this advantage, that the presence of excoriation or ulceration is at once revealed by the

blackening of the metal, which can be seen without removing the instrument.

Mrs. B——, aged thirty-nine, came under my care at the Samaritan Free Hospital in February, 1873. She had been only recently married, and was complaining of bearing down, which had come on since her marriage. I found that this was due to retroversion; and I introduced a pessary, which at once gave relief. After a few weeks I dismissed her, and had forgotten her case. About twelve months afterwards she returned, wishing to know why she had missed her period. I was careful not to use the sound, and merely satisfied myself by digital examination that the pessary was in a good position. The patient had no complaint to make of pain or even discomfort, and the instrument did not interfere with her in any way. It turned out she was pregnant. In the course of the fifth month I removed the instrument, which was as clean as if she had only worn it for a day or two. In due course she was delivered of a living child, which, however, survived only a short time.

3. The misuse of a properly-fitting instrument, or, in other words, of an instrument which, properly applied, would be found efficient. This can only arise from ignorance both of the mechanical principles and the anatomy of the parts involved. When a medical man is first shown a pessary (I am speaking of facts within my own observation), he asks how it is to be applied, apparently having

no conception as to which is the antero-posterior direction and which the supero-inferior aspect.

In October, 1872, Mrs. C——, aged thirty-two, came under my care. She had been married ten years without issue, and for a considerable time, some years, had suffered from constant pain in the region of the uterus, of varying intensity, increased by walking or even standing, bearing down in sacral region and hypogastrium, and inability to lie on right side. The menses were regular, lasting from seven to ten days, very free, often requiring twenty napkins, and painful. Micturition frequent and painful. On examination, the uterus was found so retroverted that the os pointed to the vaginal outlet, and the left ovary could be felt distinctly. I introduced a Hodge's pessary. The next morning she found herself lying on the right side, and generally experienced great relief. On her return home into the country she bore a long railway journey remarkably well, in marked contrast to her journey to town, but on her way from the railway she had the misfortune to be thrown out of the conveyance, and felt that the instrument was no longer of service to her. She called in her usual medical attendant, who removed the instrument, and replaced it a month after. Seven months afterwards she returned to town, when I found that the instrument had been put in *doubly reversed*. This case has proved a troublesome one, as this condition generally does in the barren

woman. Up to Jan. 16th, 1877, she continued to wear her instrument with the greatest relief, and on that day she reported that she felt very well, that the periods were regular, without any pain whatever, usually lasting about a week. She had no leucorrhœa, and the uterus was in very good position, admitting the sound without pain or difficulty in the normal direction. She preferred wearing the instrument, and stills wears it. During the greater (and latter) part of the time she wore the pessary in its reversed position she had a nearly constant hæmorrhagic discharge, and I found considerable congestion, with slight excoriation, for which I had to employ depletion on several occasions.

I have selected this case as much for the purpose of showing the great value of the pessary as of proving my proposition. The case was very troublesome because of the concurrent disease of the uterus.

With such evidence as I have here presented, added to the recorded testimony of a host of observers, is there any longer any ground for opposition to this method of treatment? I have heard it stated that it is only necessary to introduce the sound and turn the uterus in the opposite direction and to repeat this operation at intervals. I have done this over and over again without the slightest benefit. I have straightened a retroflected uterus with my hand in the peritoneal cavity, in the

course of ovariotomy, and with the same result of immediate relapse.

Dr. Beigel examined a large number of flexions in the dead body and was surprised at the persistence of the flexion. It has been asserted that the uterine wall is thinner on the concave aspect of the flexion. Dr. Beigel contradicts this statement in the most positive manner, and adds, that the only rational treatment is that by intra-uterine stem.*

That instruments have been abused no one is more ready to admit than I. I plead guilty to this charge, but only in the pursuit of knowledge, and in my endeavours to cure those who have committed themselves to my care, and in blind deference to the teaching of authority. But my failures have served to reveal the rocks ahead, and while I fearlessly assert that in no case have I left the patient worse than I found her, I can equally affirm that in the vast majority I have been able to render signal service.

I will not be uncharitable enough to suggest a probable cause for the unreasoning wholesale denunciation indulged in by some, but leave it to my readers to furnish their own explanation.

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* *Trans. Obst. Soc., London,* (May 2nd, 1877) p. 132.