JACKSON (A.R.)

Compliments of the Author.

LACERATIONS OF THE NECK OF THE UTERUS.

BY A. REEVES JACKSON, A.M., M.D.,

Formerly Surgeon-in-Chief of the Woman's Hospital of the State of Illinois, late Lecturer on the Surgical Diseases of Women at Rush Medical College, Fellow of the American Gynecological Society, etc.

INDEX MEDICUS JS.

READ BEFORE THE TIPPECANOE COUNTY MEDICAL SOCIETY AT LAFAYETTE, IND., MAY 6, 1880.

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LACERATIONS OF THE NECK OF THE UTERUS.

Mr. President: In response to an invitation to address your society I have selected a topic which is at the present time exciting a good deal of attention among gynecologists and obstetricians, but which there is reason to believe has not yet received such degree of consideration from general practitioners as it deserves. I allude to lacerations of the neck of the uterus.

On July 7, 1879, I read before the Chicago Medical Society a paper upon this subject, which was subsequently published.* I have embodied here some portions of the matter contained in that paper, and have added thereto some thoughts and suggestions which have been prompted by an increased experience. I intend to speak only of the practical phases of the subject, and in doing so will endeavor to be as brief as is consistent with clearness. The points to which I desire specially to call your attention are those which relate to the frequency of the lesion, its symptoms, diagnosis, and treatment.

History. The history of laceration of the cervix uteri is a short one, and its literature has been, until quite recently, meager. In 1856 Dr. A. K. Gardner† spoke of "laceration of the os and cervix" as among the causes of ulceration, enlargement of the cervix, sterility, etc., and, so far as I am aware, this was the first mention made of the lesion as a distinct pathological condition by any author. Thirteen years later (in 1869)

* Chicago Medical Journal and Examiner, August, 1879.

† The Causes and Curative Treatment of Sterility, etc., by A. K. Gardner, A.M., M.D., New York, 1856.

Dr. Emmet, of New York, published a paper in which he stated that seven years before—to wit, in 1862—he had accidentally discovered the existence and importance of the lesion in a particular case and devised an operation for its cure. This was followed in five years by another paper from the same author, in which prominence was given to the frequency of the accident and the relation it bore to the etiology of pelvic diseases. It was not until then that the attention of the medical profession began to be directed to the subject; but since that time several other papers more or less full and valuable, by various writers, have appeared in the medical journals in relation to it, and in the recent work of Dr. Emmet on the Principles and Practice of Gynecology the subject is fully and systematically treated.

Frequency. Is laceration of the cervix uteri of frequent occurrence? Many excellent persons of extensive medical experience deny that it is. They say it is inconceivable that a lesion which from the easy accessibility of the parts involved should be readily detected could escape the investigations of so many careful persons as have been engaged in treating the diseases of women all the years that have elapsed since the introduction of the speculum and other modern gynecological appliances. We might urge as a reply to such argument as this that the history of all art and science is full of examples in which the plainest facts and simplest devices have escaped discovery for centuries; that it is but a repetition of the old story of Columbus and the egg. But we can do better than this. We can advance a stronger argument—one based upon facts. The experience of Dr. Emmet, embracing observation of five hundred cases occurring in private practice, leads him to affirm that 30.80 per cent—that is, nearly one third—of "all women who had been impregnated and had suffered from some uterine disease were found to have laceration of the cervix;" and he concludes his consideration of the subject by stating that "at least one half of the ailments among those who have borne children are to be attributed to laceration of the cervix."*

* Loc. Cit. p. 480.

This is a startling statement, and one which I am inclined to believe is an exaggeration of fact. I believe that a much larger number of observations than have been made are necessary to establish the point in question. Still, the malady is undoubtedly very frequent. Dr. P. F. Mundé* found one hundred and nineteen lacerations in seven hundred women examined, and Dr. Goodell† says that his experience would lead him "to infer that about one out of every six women suffering from uterine trouble has an ununited laceration of the cervix."

As I have already said, there are many who absolutely reject this evidence and deny the facts. But it will occur to you at once that persons who have not looked for the lesion, who have not considered it as one of the conditions likely to give rise to the symptoms usually recognized as indicative of uterine disease, can hardly be in a position to form an intelligent opinion upon this subject. But more than this, as we shall see presently, those who would discover it must not only look for it; they must look for it in a proper manner, or it may elude their search.

You can form for yourselves some estimate of the frequency of the injury by recalling the number of cases in which you have discovered, when making a specular examination of women who have borne children, a soft, gaping os uteri surrounded by a red patch of irregular granular surface, sometimes readily bleeding under slight pressure, and in which, issuing from the central opening, you have observed a glairy, yellowish-white discharge—cases which, twenty-five years ago, were almost universally and by many still are called "ulceration," and by more modern pathologists are denominated erosion, granular erosion, granular degeneration, etc. These are generally cases of laceration of the cervix uteri. While these erosions unquestionably may and do exist independently of laceration, the instances in which they do so are quite rare.

* American Journal of Obstetrics, etc., January, 1879.

† "Laceration of the Cervix Uteri"—the address in Obstetrics delivered before the Medical Society of the State of Pennsylvania by Wm. Goodell, A.M., M.D., May, 1879.

Symptoms and progress. The fact that a laceration has taken place is rarely known at the time of the occurrence. When a digital examination of the pelvic organs is made immediately after delivery it is usually for some purpose connected with the removal of the placenta or blood coagula, and the attention is not directed to any thing else; but even were a possible injury to the cervix the object of search it would be difficult of detection, owing to the soft, yielding, and enlarged condition of the parts at the time. A short time after the woman has left her bed and resumes her ordinary duties she becomes conscious of an unusual amount of leucorrheal discharge, possibly tinged at times with blood. This discharge is commonly thick, yellow, and viscid in character. But I must caution you that the absence of discharge is not to be accepted as proof that there is no laceration present, for I have seen several cases of long standing and with extensive injury in which there was no discharge whatever, or at least none which appeared externally. The catamenia are likely to appear after two or three months, sometimes sooner, usually more profusely than before, and at shortened intervals. Metrorrhagia is likewise not infrequent. Sometimes, on the contrary, the menstrual discharge is diminished in quantity, while in still others it is not disturbed in any way. Sexual appetite is frequently impaired and sometimes abolished. Dyspareunia is an occasional, and sterility a frequent result.

Pains, varying in degree and character, are felt about the hypogastrium, hips, back, and thighs, together with a sense of weight and dragging in the pelvis, increased in severity when the patient is in the standing position or has undergone unusual fatigue. In some cases severe neuralgic pains referred to the region of the cervix are present, and in several the patients have complained of a peculiar pain described as "pulling" or "drawing" about the umbilicus.

In the worst class of cases no long time elapses before the lack of exercise and the persistence of pain and exhausting discharges produce their legitimate results upon the general health. Digestion is impaired, the appetite fails, the bowels become con-

stipated, assimilation is interfered with. A lessened supply of impoverished blood produces pallor and sallowness of complexion, debility, disturbed and insufficient sleep. The stomach, liver, bowels, kidneys, and especially the bladder and rectum, all contribute their quota of sympathetic manifestations, and combine to render the woman's life utterly wretched.

You will observe that the symptoms here given are not at all distinctive, and no more indicate the existence of a laceration of the cervix than they do of half a score of other abnormal conditions of the pelvic viscera. Hence they are insufficient for the purposes of diagnosis.

The symptoms produced by laceration of the cervix are not always in direct proportion to the extent of the injury — a fact frequently observed in connection with pelvic disorders in women. Usually the amount of suffering depends upon the

Fig. 1.

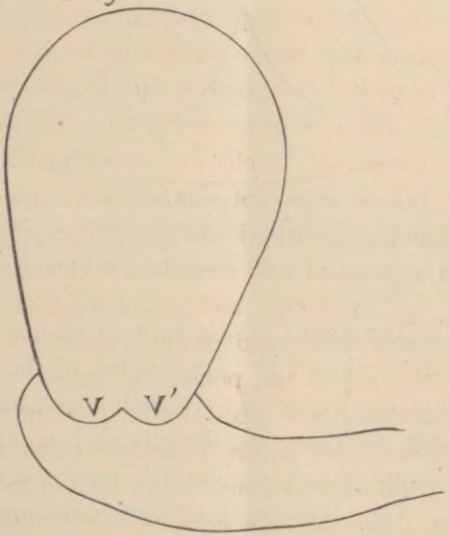

FIGURE 1.—V and V' represent the position of the uterine lips in the normal state of the parts.

degree of eversion of the lining membrane of the cervix which has taken place. This occurs in most cases where the injury has extended beyond the crown of the cervix, and reaches its

maximum where the rent is bilateral and has passed to or beyond the vaginal junction. Glance for a moment at this diagram (Fig. 1), which represents the normal shape of the parts. Here the uterine labia, V V′, are kept in apposition by the perfectly-adjusted counteraction of the circular and longi-

FIG. 2.

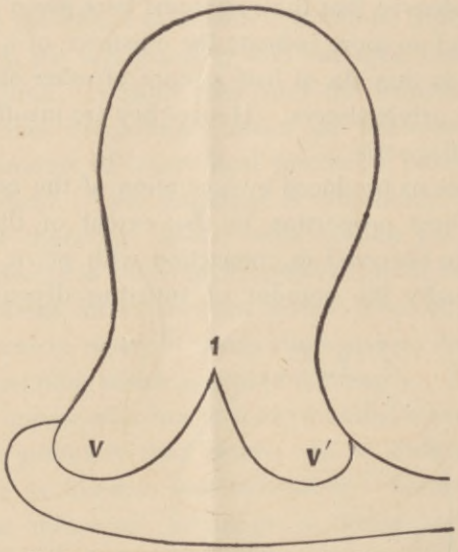

Figure 2 represents a lacerated cervix with eversion. V, the posterior lip, is crowding backward into the posterior cul-de-sac; V′, the anterior lip, forward in the axis of the vagina; 1, the upper angle of the laceration. (After Dudley.)

tudinal fibers of the organ. It is seen in strong contrast with Fig. 2, in which is shown the appearance of the parts after a severe laceration has occurred. In such a case as this, the circular fibers being unable to act, there is no power to oppose the action of the longitudinal ones, which tend therefore to drag the lips apart. The delicate epithelium covering the mucous membrane, accustomed to contact only with its own alkaline secretion, is now constantly bathed in the acid secretion of the vagina, which, acting as an irritant, soon causes its removal. This unnatural state of the parts prevents or retards the proper involution of the uterus, which consequently remains enlarged

and soft. So soon as the woman quits her bed and gets upon her feet all these unfavorable conditions are increased. The heavy uterus, inadequately sustained by its supports, presses toward and finally upon the floor of the pelvis, dragging with it

FIG. 3.

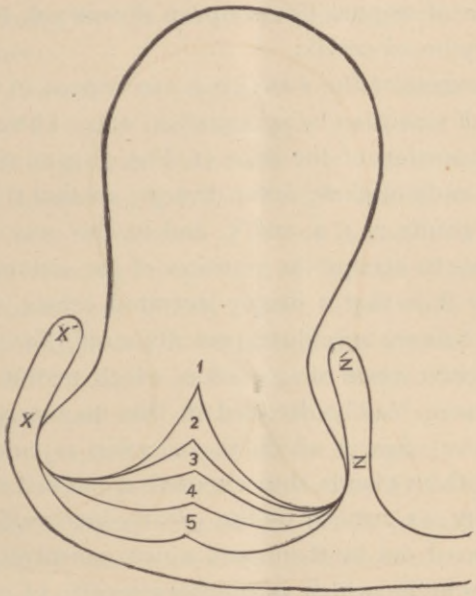

FIGURE 3.—This represents the state of the parts when eversion is complete. The curved lines forming the angles 1, 2, 3, 4, and 5 indicate the gradual process of eversion. The point 1 has been rolled out to point 5, where it appears to be the external os. The utero-vaginal junction at X and Z now appears by the reduplication of the vagina to be at X′ and Z′, thus making the cervix appear longer and broader than it really is. (After Dudley.)

the upper part of the vagina, whose walls lie in folds about it like the sides of a closed accordion, giving to the cervix an appearance of elongation. The everted and eroded surface now suffers additional irritation from the pressure and chafing to which it is subjected. The flaps are forced farther and farther apart; the extruded lining membrane, by reason of its interrupted circulation, becomes thickened and congested, and thus assists in its own outrolling. The uterus being in a state of fatty degeneration—the first stage of involution only having

been accomplished — the flaps are soft and yielding. Their inner surfaces are readily flattened out against the vaginal walls, and the entire cervical lining in some instances is finally extruded, the internal os uteri becoming the lowest portion of the organ, and appearing at the end of what seems, owing to the reflection of vaginal tissue drawn downward, to be a very long and very broad cervix.

The full extent of the eversion is rarely seen in recent cases, the process of extrusion being a gradual one. The angle formed at the upper portion of the flaps (1, Fig. 3) gradually descends as the lower ends of these latter diverge, so that it successively reaches the points 2, 3, 4, and 5, and in this way the internal os uteri comes to occupy the position of the external; and this explains why it is that a deeply-lacerated cervix, when viewed through an ordinary speculum, presents a red, *flat* surface. Indeed the slighter cases of laceration, which permit no eversion at all, are more readily detected in this manner than are the more extensive ones in which the eversion is complete.

The Nabothian glands, thus exposed, are at first stimulated to undue activity, as evinced by the greatly-increased quantity of secretion poured out by them, and which constitutes the glairy, tenacious discharge which is so characteristic of endo-cervical inflammation. By-and-by they become diseased. Their excretory ducts close, and their contents being thus retained they enlarge and form protruding roundish masses varying in size from that of a millet seed to that of a grain of barley. Some of these rupture, and their open mouths add an appearance of increased roughness and rawness to the already eroded surface. Before bursting they may frequently be felt as small shot-like bodies in the tissues.

When the injury is confined to one side the eversion of the cervical lining is not so marked, and occasionally does not occur at all, even when the rent has extended to the vaginal junction. In these cases there has usually taken place some degree of union at the bottom of the fissure, and the cicatrix thus formed restrains, partially or wholly, the tendency to protrusion.

Diagnosis. As already stated, the subjective symptoms are never sufficient to enable us to do more than suspect the existence of a laceration of the cervix. But they are of such a character as should *always* impel us to make a physical examination; and if we do this, and do it properly, we need never remain in doubt; for the diagnosis may be made in the most definite manner.

In many cases this can be done by the touch alone. The patient should lie upon the back, with the knees drawn up and separated. A finger introduced into the vagina may detect the uterus in its normal situation, although usually it is depressed and more or less retroverted. The os is patulous, and its borders and the entire vaginal portion of the cervix are of softened texture and commonly unduly tender to pressure. If there be laceration present, and if it be of such extent and nature as to permit eversion, as shown in Fig. 2, the cervix will be felt apparently enlarged, and the distance from the os to the vaginal junction much greater than usual, as though the cervix were elongated. If the finger be now carried up to the vaginal junction and made to sweep around the cervix at that point it will be found notably smaller than the portion below. When these conditions can be clearly made out they may be considered as very strong evidence of the existence of laceration with eversion.

But there is a test which I regard as infallible. Let the patient be placed in the knee-chest position, and then introduce a Sims speculum or other form of perineal retractor, and if the parts have been seen before through a tubular or bivalve speculum with the patient on the back, an astonishing change will be found to have taken place in their relation to each other as they now are brought into view. The uterus, falling away from the vulva by its own gravity, carries with it the upper portion of the vagina, thus causing the unfolding, as it were, of the latter organ and its restoration to its full length. Not only is the apparent elongation of the cervix thus reduced, sometimes to the extent of one or two inches, but the size of the eroded surface is likewise diminished from the partial inrolling of the cervical lining

membrane. If, now, while an assistant holds the speculum, the anterior and posterior flaps be seized with tenaculæ at the points V V′ (Fig. 2), and drawn toward the vulva and toward each other, the eroded surface will be found to disappear; that is, the intra-cervical mucous membrane will be restored to its proper place, and the vaginal portion of the cervix will resume its natural form and almost its natural size. If this can be done it amounts to a demonstration. There is no other condition or combination of conditions in which this maneuver can be accomplished with these results.

But to obtain this certain evidence the necessary means must be used and the conditions complied with. In such a case as that described, when the parts are observed through an ordinary cylindrical or valvular speculum, it is frequently impossible to command a view of the entire cervix, so widely are the lips spread apart. The ends of these latter, which the observer thinks he is looking at, are not visible at all. The red, raw-looking mass appears to the unpracticed eye as though hypertrophied and ulcerated. Indeed these constitute the so-called severe cases of ulceration for which powerful and protracted cauterizations were formerly the approved and usual remedies.

Diagnosis. The maladies with which laceration of the cervix may be confounded are thickening and elongation of the cervix, simple granular erosion of the os and cervix, true ulceration, and epithelioma.

When there is actual enlargement of the cervix from other causes than laceration—for of course the two conditions may coexist—the part is gradually increased in diameter from below upward toward the body of the organ, but in laceration with eversion the lower portion is the largest; and as the body of the organ is approached there is a more or less distinctly-marked narrowing, so that the shape of the vaginal portion has been compared to that of an inverted mushroom.

From elongation of the uterine neck—the so-called hypertrophic elongation—laceration may be distinguished, as already

stated, by placing the patient in the knee-chest position. Here the apparent elongation which is present in some cases of laceration entirely disappears, by discovering the true vaginal junction, whereas if the elongation were real the part would project as far into the vagina as before.

Granular erosion of the os and cervix sometimes occurs from irritating contact of catarrhal discharges, but uncomplicated with laceration it is a comparatively rare affection.

It should not be a matter of surprise that the red, roughened, eroded cervical lining seen in cases of laceration should have been so frequently and for so long a time mistaken for ulceration. But if by the term ulcer we mean to designate a condition in which there is loss of substance beyond the epithelium it is comparatively rare in this locality. The only true ulcers of the cervix are those produced by friction and exposure when the uterus is procident, or which are the result of chancroid or carcinomatous disease.

It is likewise not wonderful that the extruded lining membrane, studded with enlarged follicles, elevated and swollen, bleeding readily, and bathed with muco-purulent secretion, should have been frequently mistaken for malignant disease. But from all these conditions — simple erosion, ulceration, whether benign or malignant — presenting a reddened, roughened, raw surface, laceration with eversion may be certainly distinguished in the manner already indicated.

Let every one bear in mind that laceration is frequent and that hypertrophy is rare; that eversion is frequent and ulceration rare; and it will lead to the adoption of this practical and only safe rule, namely, Whenever the cervix uteri appears enlarged and denuded of tissue, make the trial test which I have described, and all doubt will be cleared away.

Treatment. If the foregoing views as to the nature and pathology of laceration be concurred in, the indications for treatment become as clear as that for harelip. While it is possible in many cases, especially of the milder forms of the injury attended by slight eversion, to effect a cure of the erosion by means of as-

tringents and stimulating applications, the improvement is only temporary usually, and in most cases does not take place at all. Having realized the inefficiency of these "applications" and "treatments," Dr. Emmet devised and practiced an operation to take their place—an operation so simple that any one who has ordinary dexterity may perform it; so safe that it has never caused a fatal result; and so effectual that it accomplishes in a fortnight what alteratives and caustics can not effect in years, namely, an abiding cure; an operation which, instead of destroying the normal structure of the part, restores both its shape and almost its natural size. Having had occasion to perform this operation quite frequently, I have from time to time modified its various details, with the view chiefly of shortening the time of its performance, so that it has now come to differ from that of Dr. Emmet in almost every particular.

The instruments I employ are few and simple. They consist of a perineal retractor, a small double vulsellum forceps, a tissue-holder, a needle of peculiar construction, two pairs of scissors, and, where silver wire is used, an adjuster and twister. The use and application of each of these I will endeavor to exemplify.

The patient having been etherized, is placed upon a table properly prepared with bedding, sheet, pillows, etc. The table need not be more than four feet long. While the semi-prone or knee-chest position is the best for the diagnosis of laceration, I very much prefer the dorsal for this and all other operations upon the cervix. The patient is drawn forward so that the coccyx projects four or five inches beyond the end of the table, the head and shoulders being well raised. Each lower limb is placed in charge of an assistant, by whom the thighs are abducted and moderately flexed on the abdomen. These two assistants should face the operator, and each should command the thigh of the patient with the arm nearest the latter. In this way each of them will have a hand at liberty for any other purpose that may arise. Two other assistants are necessary—one for the administration of the anesthetic; the other to hand instruments, use sponges, etc.

The operator, seated in front, now passes one or two fingers of the left hand into the vagina, and, having ascertained the position of the cervix, with the right introduces the retractor. The blade of this instrument is much broader, flatter, and shorter than that of Sims's speculum, and is, I think, much more convenient than the latter for all uterine operations done in the dorsal position. This is guided to its place in the posterior cul-de-sac by the fingers in the vagina, and the perineum being pressed backward while the vaginal walls are separated laterally the cervix is readily brought into view. The retractor is now given in charge of one of the assistants, who takes it with his disengaged hand. The anterior flap of the laceration is next seized with the vulsellum forceps and drawn down to the vulva. If necessary, this should be aided by supra-pubic pressure. Both flaps are now brought together, with the view of determining accurately the extent of the laceration, the proper position of the external os uteri, the amount of tissue to be removed, the number of stitches necessary for closure, etc. This having been done, a needle, such as I here show you, is passed through the anterior flap, which is steadied by the grasp of the vulsellum. The needle is rectangular in shape, with a very strong, short shank affixed to a handle. The needle proper has no eye, but on one edge of its flattened blade, near the point, has a notch for the purpose of catching and carrying a wire or silk suture. This device is a modification of Skene's perineal needle. The requirement here is for a needle which shall be sufficiently strong to be pushed through the tissues (which are sometimes extremely dense), and which at the same time can be quickly threaded.

The needle is passed through as stated, unarmed, and so soon as its point appears the loop of a strong silk cord is caught in the notch of the needle by the assistant. The needle is then withdrawn, leaving the silk in the flap. The vulsellum is now transferred to the posterior flap and the same process repeated. By means of these threads, which should be sufficiently long to enable the assistant who has charge of them to draw them in

any needed direction without incommoding the operator, complete control of the cervix is had throughout all the subsequent steps of the operation.

Fig. 4.

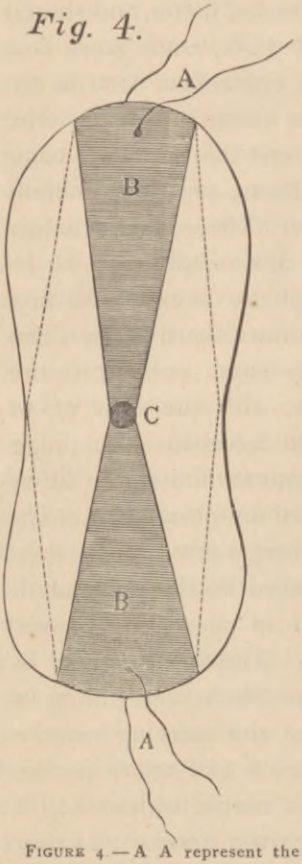

FIGURE 4.—A A represent the guiding threads in the labia, marking the center of the restored os uteri; B B, strips of undenuded tissue to form the continuation of the cervical canal; C, the apparent os uteri externum. The dotted lines indicate the direction in which the freshening of the surfaces is made.

I formerly used a single thread which passed through both lips, but this prevented the easy separation of the latter, and I find the mode I now adopt much more convenient.

The next step consists in making raw the surfaces which are to be joined together. This is better and quicker done by scissors, and the cut surface bleeds less than when the knife is used.

The shape and size of the flaps determine the amount of tissue to be removed. Sometimes when the lips are not much thickened and present a flat surface it is only necessary to take off a thin layer; but where they are hypertrophied and have a rounded, bulging surface, the entire convexity should be cut away. A practical and safe rule is to remove enough tissue to permit the opposing surfaces to be brought easily into contact. Care should be taken not to freshen the edges too near the center of the flaps, lest their subsequent union result in obliteration or narrowing of the external os. A space at least half an inch long should be left for this opening, for the subsequent shrinkage of the part will reduce this to the proper size. The denuded portions of the opposing surfaces should be equal in length and width, so that when brought together they may be accurately coaptated. (Fig. 4.)

The passing of the sutures is sometimes very difficult, owing

to the thickness and density of the tissues. When ordinary needles are used it is necessary to have a strong needle-holder—one which permits the needle to be placed at any angle. The needles should have a cutting-edge near the point, and should vary in length from three fourths of an inch to an inch and a quarter. They should be thick enough to allow of a large eye through which the loop of a doubled silk thread may pass. The eyes of most needles are too small. I formerly met with many cases in which there was difficulty in this step of the operation. I then used Emmet's needle-holder and vesico-vaginal fistula needles, but since I have made use of the needle just shown you I have found little or no trouble in this way. The first suture is passed at or near the inner angle of the fissure. The part being steadied by means of the vulsellum, the point of the needle is entered about a quarter of an inch from the edge of the freshened surface, and is made to emerge just at the edge of the undenuded strip which has been left for the continuation of the cervical canal. It is then reëntered at the corresponding point opposite, and, passing through the other flap, finally issues at a point opposite that of its first entrance. A silver wire eighteen inches long, bent at a sharp angle an inch from one end, is then hooked into the notch of the needle, and on the withdrawal of the latter is left in place. Unless the flaps are of unusual thickness the needle may be thus passed through both of them before attaching the suture; and in that event it is unimportant through which flap it is passed first, although I usually prefer the posterior as being more convenient. But where they exceed a thickness of half an inch each it is better to transfix one at a time, and then it will be found easier to pass the needle first into the denuded surface of the anterior lip, and after placing the suture to detach the latter and reintroduce the needle from the vaginal side of the posterior flap, and then finish as just stated. The number of sutures required will vary according to the extent of the fissure. Usually from two to four are needed on each side. They should be placed about one third of an inch apart.

Either silk or silver wire may be used for the sutures. I have nearly always used wire, and know it to be reliable. Others prefer silk, and consider it equally good.

The sutures having all been inserted, the patient should be placed in bed, where ordinarily she ought to remain until the stitches are removed. This may be done as early as the eighth day; but I prefer, unless the prolonged confinement is especially irksome or contra-indicated, to allow her to remain until the ninth or tenth. In one case, in which they were removed on the eighth day, the adhesion of the flaps was so feeble that they subsequently separated, and a repetition of the operation became necessary.

The operation is not a very painful one, and an anesthetic is not always necessary, although usually desirable. I have operated on several occasions without using any, and the only complaint made generally had reference rather to the irksomeness of the position than to the other procedures.

Neither is there much pain or discomfort felt after the operation. Indeed patients usually suffer so little from it that it is difficult to make them appreciate the necessity for lying in bed afterward. And it is possible that this necessity has been overrated. Several times patients have, contrary to my directions, resumed many of their ordinary duties after the third day. In one case, on the second morning after the operation, I found the patient dressed and sitting up, and she informed me that she felt less discomfort in the parts than she habitually did before the operation. In none of these cases did the seeming imprudence produce any bad result or prevent a successful issue. Dr. Skene states that he has operated eight times at his office and sent the patients home on the street-cars.

After-treatment. At the close of the operation I am in the habit of placing in the vagina the ordinary cotton tampon saturated with glycerin, with a string attached to facilitate its removal, and in the rectum a suppository of cocoa butter containing two grains of opium and one sixth of a grain of extract of belladonna. The tampon should be removed on the day

following the operation, and the vagina should be carefully washed once or twice daily with warm water slightly carbolized. It is not necessary to prohibit the patient from leaving the bed to urinate or for other necessary purposes. Rarely I have had to use the catheter once or twice. The bowels, if not open spontaneously, may be acted upon by a mild laxative, followed by an enema on the fourth or fifth day.

Reasons why the Medical Profession does not accept the facts of Laceration of the Cervix Uteri.

As I stated in the outset, a comparatively small number of the members of the medical profession have given any attention to the subject of laceration. Many to whom the facts have been presented have contented themselves with denying their existence without making any effort either to prove or disprove them. Some who can not be supposed to be unfamiliar with what has been written upon the subject seem to ignore it altogether. As an example of the latter class, I may mention the name of so great and prominent a teacher and author as J. Matthews Duncan, who, in his recent work on the Diseases of Women, referring to a case of chronic catarrh of the uterus, thus describes the state of the parts as revealed by physical exploration: "*Per vaginam*—cervix uteri is in normal situation, considerably enlarged by expansion so that two fingers can easily be introduced; quite soft, and partially denuded of epithelium, and secreting a yellow muco-pus." A patient in such physical condition would have a uterine catarrh certainly, but what would be its cause? Can any one doubt from the description that this was a case of laceration with eversion?

But this need not surprise any one. All new truths in medicine, or rather those which seemed new, have been met in a similar manner. There are, however, some especial reasons why laceration of the cervix and its pathological importance have not been recognized, and upon these I desire to comment briefly. They are as follows:

1. *The frequent neglect of physical examination.*—It is too much

the custom among physicians to base their treatment upon the subjective symptoms alone. In the disorders of women such a course can rarely be successful. It is simply guess-work—guessing at the diagnosis and guessing at the treatment. During the child-bearing period of life especially there are comparatively few of these disorders that do not originate in, or extend their influence to the reproductive organs, and if these latter be not interrogated very important elements of diagnosis are likely to be omitted. A faulty or imperfect diagnosis results in erroneous if not injurious treatment. The debility, nervousness, anemia, and other results of organic pelvic disease are treated by so-called tonics, nervines, and blood-restorers, while the underlying cause of all the mischief is allowed to continue its destructive work. It is as though the pumps of a sinking vessel were worked and no effort made to stop the leak. Where there are present in any given case such symptoms as deranged menstruation, more or less constant leucorrheal discharge, headache, pelvic, vesical, or rectal pains or discomfort, the indications for a physical examination of *all* the pelvic organs should be considered imperative and an essential prerequisite to treatment. Yet I know that patients suffering from such manifestations of disease are frequently treated, sometimes for many months, without any adequate means having been taken to ascertain the condition of the parts in question. Such negligence as this would result not only in the failure to detect a laceration, but any other morbid condition of the pelvic organs.

2. *Faulty methods of examination.*—Among those who are diligent enough to make physical exploration when it seems demanded, there is much room for criticism as to the manner in which it is done. The most common fault is perhaps a want of due care. Many facts which might readily be ascertained are not even sought for. This need not be for want of proper instruments. The very best of these—the index finger—is always at hand. It is the most valuable of all gynecological investigators, and when properly educated and used to the full extent of its capability there is scarcely any of the pathological con-

ditions of the pelvic organs in women which can escape its detective powers. The tubular speculum, which is exclusively used by many, is not only incapable of aiding in the discovery of laceration of the cervix, but actually prevents such discovery. The various valvular specula, while not quite so useless for this purpose, are nearly so. Neither of these forms of the instrument are valuable for diagnostic purposes. None of them permit, except in a limited degree, the sort of exploration which is necessary. The duck-bill speculum has never become popular in private practice, and it is doubtful if it ever will. It can only be used with the aid of an assistant—an objectionable feature to many women—and some degree of exposure almost necessarily attends its employment. Its efficient use is likewise frequently productive of pain. For these reasons it is comparatively seldom used. And yet, as we have seen, without it a laceration of the cervix is almost certain to escape detection.

3. *Reluctance to abandon old doctrines for new ones.*—Physicians, as a class, are conservative, and this is well. When they are asked to give their assent to new facts and new doctrines they do rightly to ask for proof of the correctness and genuine character of the new things. When, however, they not only do not ask for such proof, but deliberately refuse to receive it when offered, they çease to be conservative; they are bigoted. Are any of us free from this fault? We all know that it is not pleasant to give up old beliefs, old modes of thought, and adapt ourselves to new ones. Humiliating though it be, it is a fact that truth is not welcome to us unless it come quietly and take its place side by side with that which has come before. If it approach as a displacer or usurper we do not bid it enter, but guard our portals against it.

Applying these remarks to our present subject, we can at once appreciate the dilemma in which many physicians find themselves. If they admit the frequency and importance of laceration of the cervix they must abandon the long-cherished phantom of ulceration; they must acknowledge a long persistence in erroneous opinion and practice: if they abolish the

theory of "womb-ulcers" they must cease "burning them off"—a fee-getting, if not a health-giving practice. When a man's knowledge of womb-diseases is limited to "displacement" and "ulceration" he can not afford to relinquish much, or he will have no uterine pathology left! The establishment of the facts of laceration implies the abandonment of the ulceration theory and the speculum-and-caustic treatment which was its legitimate offspring—a mode of treatment which embodied more professional malpractice than it is possible to estimate; that has produced in untold hundreds of women deformed, maimed, and sterile wombs; and that has resulted, both by what it did and what it prevented from being done, in more injury to the health and happiness of the women of this land than a generation of enlightened physicians can atone for.

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