Byrne (J.) Compliments of J. Byrne

CONTRIBUTIONS TO GYNÆCOLOGY.
NO. 3.

A CASE OF

RETROVERSION OF THE UTERUS,

OF EIGHTEEN YEARS' STANDING,

SUCCESSFULLY TREATED BY ELYTRORRHAPHIA.

With Clinical Remarks.

TO WHICH IS ADDED A SUPPLEMENTAL HISTORY OF THE SAME CASE.

READ BEFORE THE NEW YORK OBSTETRICAL SOCIETY.

By JOHN BYRNE, M.D., Etc.,
SURGEON TO ST. MARY'S FEMALE HOSPITAL OF BROOKLYN.

(*Reprinted from American Journal of Obstetrics and Diseases of Women and Children, February*, 1869.)

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RETROVERSION

OF THE UTERUS.

Mr. President and Members of the Obstetrical Society :—In response to your polite invitation, I have the honor to submit the following history of a case which, on account of its many unusual features and long duration, as well as the happy results of treatment, cannot fail to interest every member of this Society.

E——, æt. thirty-five, was married at sixteen; cannot remember whether the catamenia appeared previous to that time, but says she gave birth to her first and only child about one year after. Since then—now over eighteen years—she has not known a single day's good health, and her pinched and care-worn features, and utterly helpless condition painfully testify as to this latter statement.

Soon after her confinement she began to complain of great distress and difficulty in passing water, and bearing-down pains "as if her insides would fall through."

Objecting, through feelings of delicacy, to make her condition known, neither medical nor surgical aid was invoked, and after some time, she learned to endure in silence, pain and suffering for which she thought there was no remedy. At twenty she was a widow, and has never married since.

Ten years ago, having to support herself by hard work, and while in the act of lifting a heavy weight, a femoral hernia appeared, which, becoming strangulated, was relieved by the usual operation required in such dangerous accidents.

Very soon after her recovery, and ever since, she has been obliged to wear a truss, and about six months ago, being unable to afford the luxury of a properly constructed instrument, the intestine became strangulated a second time, and again she had to undergo the necessary ordeal to save her life, and with the same result as before.

She now applied for admission to the hospital under my charge, on account of, as she said, "*falling of the womb*," which had latterly become so aggravated that she found herself unable to do any kind of work, and, as a consequence, utterly destitute. The least muscular exertion in the way of locomotion, or even maintaining the body in the erect position for any length of time, was followed by the protrusion, *externally*, of a tumor as large as a clenched fist. When this occurred, which was almost daily, she was obliged to take to her bed at once, and every effort she could make often failed to return the mass within the vulva for many hours, during which no urine could be voided, and the pelvic pains and tenesmus could only be compared to those of hard labor. Her bowels would not act without the aid of medicine, and every dose was almost sure to be followed by a repetition of the same terrible suffering.

The protrusion having been returned within the pelvis, it was found impossible at first to decide as to what it

really was, as no os uteri could then be traced, and the parts being in an inflamed and irritable state, the most careful manipulation occasioned great pain.

It seemed to occupy the whole lower pelvis, and a finger inserted within the rectum came in contact with the mass about an inch from the verge of the anus, but no amount of pressure then deemed justifiable, could succeed in moving it. She was ordered flaxseed tea injections to open her bowels, the horizontal position was strictly enjoined, and catheterism resorted to twice daily.

In the course of the succeeding two or three weeks repeated examinations were made without resulting in any very positive diagnosis, and at the last of these explorative efforts, Dr. C. L. Mitchell being present, I availed myself of his valued aid in helping me to clear up the mystery. It was now found that by carrying the finger far up behind the symphysis pubis it came in contact with a thick, indurated, and uneven flap, resembling to the touch the edge of a small-sized placenta, only harder, but whether it was the hypertrophied lip of a uterus or something else could not be decided satisfactorily, as every effort to introduce a sound or bent probe beyond this angular projection, and backward, utterly failed (Fig. 1). Thus, a provokingly uncertain knowledge of the true nature of her difficulty continued up to August 3, when, finding her general health much improved, and all pelvic pains in a great measure relieved, I determined to make one more attempt to dislodge the tumor to an extent at least sufficient to aid me in arriving at a correct diagnosis.

Having emptied the bladder, the patient was now

placed in the knee-elbow position and supported by the aid of a nurse. A strong inflatable rubber bag was pushed within the anus and distended by means of a

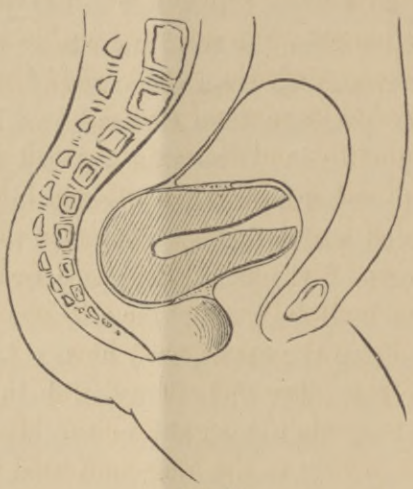

Fig. 1.

"Davidson's syringe" to a capacity compatible to this limited space. A tenaculum was next carefully insinuated between the symphysis pubis and the edge of the thick flap already referred to, and when supposed to have cleared this projection, was now turned half around, so as to grapple the tissues. Two fingers of the left hand were then applied to the lower surface of the inflated bag within the rectum, and thus, by strong and steady pressure forward and downward kept up for some time, while traction in an opposite course was made by means of the tenaculum, the mass was soon felt gradually but perceptibly to move a little forward.

The rubber bag being now further distended, so as to secure the little advance gained, the tenaculum was un-

hooked, and with but little difficulty, the finger inserted above the projecting lip, and by which means an additional amount of tractive power could be applied. These manipulations, kept up at intervals for about five minutes longer, were crowned with success, *and the womb was now, probably, for the first time in eighteen years, restored to its natural position.*

At this juncture, and feeling a great desire to inspect the object of all my laborious efforts, I thoughtlessly relaxed my hold, and opening the stop-cock attached to the rubber bag, was not a little mortified to find that the uterus immediately rolled back to its old bed. But little difficulty was experienced, however, in restoring it to its proper place once more, and the tenaculum enabled me to retain the organ in situ. It was now discovered that, owing to the long-continued strain on the anterior vaginal wall, there was a new, and by no means trifling, difficulty to be contended against; namely, cystocele. The vaginal portion of the uterus presented a most remarkable appearance, being composed of two enormously enlarged labia, separated by a deep transverse fissure near the centre, and at the bottom of which a sound was made to enter and pass up four and a half inches into the cavity of the uterus.

Fig. 2 correctly represents the appearance of the parts when the vagina was distended by the aid of a Sims' speculum, and the uterus kept steadied by a tenaculum. A large-sized hinged stem pessary, usually known as Detschy's modification of Zwanck's instrument, served to retain the organ in situ; the bowels were kept well opened by enemata, and with the hope

of still further improving her general condition I prescribed the following:

℞. Tinct. Ferri Mur., ʒ vi.
Ammoniæ Mur., ℥ ss.
Aquæ, ℥ viii. M.

Fiat mistura. Sign.: A tablespoonful in a wineglassful of cold water, three times a day.

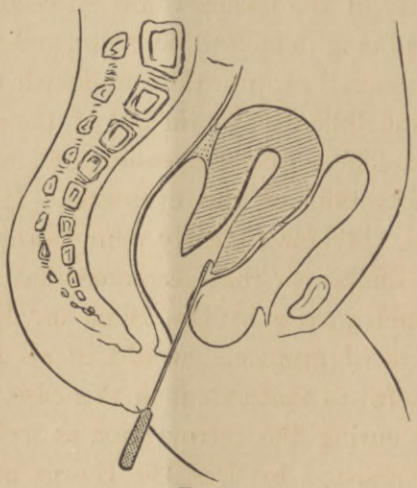

Fig. 2.

Within two weeks from this period she became able to exercise with great comfort, and her general appearance improved wonderfully; but on the approach of menstruation, which, however strange it may seem, was never interrupted during all her years of suffering, the pessary became a source of much discomfort, was not at any time capable of supporting the prolapsed bladder, constantly half filled as it was with urine, and at her urgent request it was removed. The uterus, though

inclining backwards, did not become retroverted, and absolute rest in the horizontal position was once more enjoined.

In a subsequent investigation it was observed, that when the anterior vaginal wall was firmly seized by a hooked forceps, and at the same time by a sound in the cavity of the uterus, efforts were made to produce retroversion, no amount of force compatible with the integrity of the tissues could succeed in doing so; the forceps being detached, however, and the tension on the vesico-vaginal septum thus removed, there was not the slightest difficulty, by the aid of the sound, in producing any degree of retroversion, and with a proportionate reduction of the cystocele. It was by this experiment, therefore, clearly demonstrated, that some operation similar to that recommended and practised with so much success by Drs. Sims and Emmet for the radical cure of cystocele, would in all likelihood not only be useful to that extent in this case, but succeed in effectually curing the retroversion as well. With this view, and assisted by Drs. De Bowes and Whaley, I proceeded on the 13th November to operate as follows:

The bladder having been emptied, and the patient placed on her left side, a Sims speculum was adjusted and taken charge of by a capable nurse. An instrument (Fig. 3) devised for the occasion was bent to the shape desired, and applied in the manner shown in Fig. 4. By this means the uterus was kept steady and the base of the bladder inverted in such a manner that when two apparently paralled surfaces were de-

nuded, the space between, when spread out, would necessarily be somewhat elliptical.*

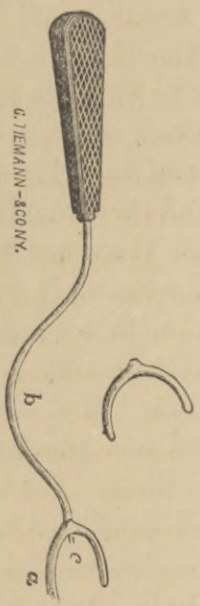

Fig. 3.

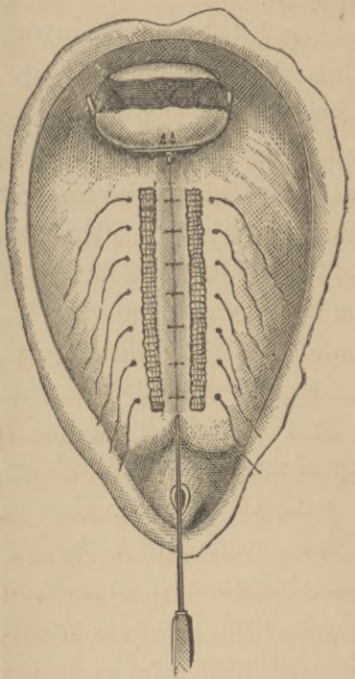

Fig. 4.

* The utility of this little instrument consists, first, in its adaptability to any case where elytrorrhaphy is required, the shaft or stem being copper; second, the semicircular rest is firmly fixed by means of a sliding spring, but so adjusted that it can be readily released; and, third, the delicate fork attached affords additional aid in keeping the uterus not only elevated but anteverted.

In the case of E——, I, at first, proposed to unite the anterior lip to the vagina on either side of the raphé, but this was subsequently abandoned as being unnecessary. However, in cases of prolapsus uteri, when such a proceeding is, for the most part, indispensable, the advantages offered by such an instrument must be obvious, and its removal is not called for until every step of the operation has been completed.

The two lines of denudation extended from about half an inch behind the ostium urethræ to within the same distance of the utero-vesical angle, and the surfaces thus prepared were brought into close apposition by seven interrupted silver sutures. An anodyne suppository was now administered, and the bladder kept empty by means of a fixed catheter. On the eighth day the four lower sutures were removed, and on the thirteenth, the three remaining also taken out, when the parts were found to be completely and firmly united, and the uterus securely held in its proper position. The sound was now introduced for the purpose of testing the power of the parts to resist forcible backward version, but the result was the same as that noticed in the experiment made before the operation.

Remarks.—The above case presents many interesting features, and will doubtless suggest to the mind of the gynecologist important reflections touching displacements of the uterus generally. This poor woman's malady was, probably, quite manageable in its early stage, but her most prominent and troublesome symptoms being imperfect defecation, and difficulty in emptying the bladder, with their attendant tenesmus, and this distress continuing for years, a case of retroversion of the first or second degree was gradually converted into one of prolapse of the already displaced organ, and ultimately complete version.

Various surgical measures, having for their object a more or less permanent contraction of the vagina or its outlet, have been suggested and practised, especially during the last thirty or forty years, sometimes for

cystocele, and perhaps more frequently for procidentia or prolapsus uteri.

Some of these operations are well known to be worse than useless, while others are only practicable for the most part when the patient has arrived at an advanced age, but even then often quite inadequate to afford the needed relief.

It is, therefore, now universally admitted by every surgeon who has had practical experience in such cases, that some proceeding such as that first suggested by Dr. Sims, and subsequently improved if not perfected by Dr. Emmet, offers the only reliable means of treatment.

It is true, every measure heretofore suggested, the latter even included, has failed to meet the approbation of some authors; while others, whose contributions to gynecology are deservedly held in high esteem, say nothing whatever touching this plan of treatment, though devoting pages to the consideration of various forms and shapes of pessary supposed to be beneficial in these ailments.

Professor Scanzoni tells us that he has tried *elytrorrhaphia* thirteen times, and has no hesitation in pronouncing unfavorably of the operation, because "contraction obtained by *elytrorrhaphia* yields in the course of a few weeks after the operation, in consequence of the pressure exerted by the uterus descending into the vagina." Dr. West also records his want of confidence in these measures, and, in order to strengthen his disapproval, cites the experience of Scanzoni.

In spite of such unfavorable opinions, however, I venture to assert that there are few operations in the

whole range of conservative surgery attended with less risk to the patient, or more promising as to results, than that proposed and practised nowadays for the radical cure of cystocele and prolapsus uteri, but especially the latter.

As already remarked, many operations said to be successful, and lauded by their originators only, are open to grave objections; but as I believe no surgeon, in this country at least, has seen fit, for many years back, to practise perineorrhaphy, partial or entire closure of the vulva, pinching or cauterization, for the cure of prolapsus, such objections, I contend, have no application whatever to the present method of operating.

The unfavorable experience of Prof. Scanzoni, therefore, and the strictures of Dr. West and others, can only be accounted for by attributing to these illustrious authorities an imperfect conception of the correct method of proceeding in order to attain the desired end.

One of the principal objections to elytrorrhaphia, and indeed the only one worthy of notice, is, that in narrowing the vagina we thereby create a serious obstacle to further parturition, and that in case this obstruction should be overcome in labor, it is likely to be attended by dangerous laceration of the cicatrized parts, and, therefore, a worse condition than that for which the operation was originally resorted to. However, the most aggravated case can never demand an amount of narrowing sufficient to impede labor or endanger laceration, but only to an extent approximative to the normal state of the parts. In patients who have passed the menstrual period of life, much exactness is not demanded; but in

others it is of the highest importance that the surgeon should remember to anticipate future contingencies as well as to estimate more immediate results. I have treated cases of cystocele and prolapsus in St. Mary's Hospital by Dr. Emmet's modification of Dr. Sims' operation; and, except the simple cicatrix, there is no appearance of anything having been done, and certainly no strikingly abnormal narrowing. Moreover, in the case of E., I have several times inflated a strong and large-sized air pessary to its fullest extent, and by a sound in the bladder and a finger in the rectum, satisfied myself that there was still ample space to accommodate a fœtal head. Besides, if the cicatrix should give way during parturition, it by no means follows that the bladder should necessarily become involved in the laceration.

The happy accident related by Dr. Sims when he first attempted a radical operation for cystocele, no less than our knowledge of the anatomical relations of these two distinct structures, demonstrate that the amount of intervening connective tissue is very great.

On the whole, therefore, it would seem that objections made to these and similar operations are based upon purely theoretical assumption, or at least inadequate practical observation on the part of those who venture to criticise them.

Retroflexion of the uterus is a lesion by no means rarely met with, not only as superinduced by incomplete, irregular, or arrested involution, but also as one of the results of parenchymatous metritis, occurring in any condition of life, whether married or single. In-

deed, among the numerous well-marked cases of chronic metritis always to be encountered in a public institution, we will find flexion more or less, in some form, but generally backwards, to be an exceedingly frequent and often troublesome complication. It is needless also to say that *this* particular malady can never by any possibility occur as a purely idiopathic lesion.

Retroversion, on the other hand, is by far less frequent in its occurrence, is most generally an accident connected with the early period of gestation, though by no means so exclusively confined to this state as many observers think, but always a more grave and sudden form of displacement than the former. The symptoms, also, are more acute and alarming, and give rise to a greater amount of constitutional disturbance, principally because of their rapid development. The following case illustrates its occurrence from traumatic influences, and as a purely idiopathic lesion in the non-puerperal state.

On the fourth of May last, I was sent for to see Mrs. L——, aged 25. Has been married five months, and always enjoyed perfect health; menstruation regular, and the last "*period*" ended one week ago. Three days before, when coming down stairs, her foot slipped, and while in the act of recovering her balance, she felt as if something had given way in her back. She was at once seized with severe "bearing-down pains" and great desire to pass water, which could only be accomplished to the extent of a teaspoonful or two at a time. This latter distressing symptom abated somewhat in the course of forty-eight hours, so that when I saw her she said she had succeeded by frequent efforts

to void a considerable amount of urine. Her bowels were constipated before the accident, and though castor-oil had been taken subsequently, no movement followed. A vaginal examination revealed *a hymen in a state of virginal perfection*, having an opening through which the index-finger passed with difficulty. The os uteri was pushed against and facing the symphysis pubis. A finger introduced into the rectum readily came in contact with a firm but not large tumor, and permitting the further passage of the finger between it and the sacrum.

A few ounces of urine having been drawn by a catheter, the patient was placed in the position most likely to facilitate reduction, viz., knee-elbow. In spite of every entreaty, she refused to allow me to remove the obstruction referred to, by bistoury or scissors; consequently, I was obliged to rely almost entirely on efforts made per rectum. A little patient manipulation, however, fortunately enabled me to dislodge the uterus, which in returning seemed to pass by a mass of accumulated fæces above. A soap and water enema was followed by copious fecal discharges, but the uterus did not resume its previous horizontal position. She is now in the enjoyment of excellent health and menstruates regularly, but still objects to surgical interference for the removal of a difficulty usually disposed of in sexual congress.

That chronic parenchymatous metritis is a frequent predisposing cause of *retroflexion*, I have had ample means of verifying, and at present there are three well-marked and instructive cases of the kind under treatment in St. Mary's Hospital. Two of these are married—one the mother of three children, the youngest four years

old, and the other sterile, and has not menstruated for six years. The third suffers from aggravated dysmenorrhœa, and the first from painful and irregular menstruation.

Two of these cases—and perhaps it would be safe to say two out of three met with in practice when any treatment has been pursued—have been cauterized to their hearts' content for "*ulceration*," but with no other result than might be expected from the use of urethral suppositories for subduing inflammation of the bladder, or gargling the throat to cure gastritis.

A vast majority of such cases will, I think, be found quite curable by judicious treatment, constitutional as well as local, and when guided by a scientifically accurate knowledge of their pathology.

The predisposing causes of *retroversion*, and, indeed, of every other recognized "disorder of place," are doubtless well understood, and, for the most part, avoidable at first, or subsequently remediable. Consequently, if I am correct in this assumption, it is of the utmost importance to bear in mind that patients suffering from chronic metritis, whether catarrhal or parenchymatous, or both, and if in a limited degree, though even with some retroflexion, may nevertheless become pregnant.*

Dr. Tyler Smith has long since expressed the opinion that pregnancy occurring under such conditions might likely be attended with a still greater degree of displace-

* Inflammation of the intra-uterine mucous membrane, usually termed endometritis, is so seldom found unassociated with more or less parenchymatous complications in married women, that by catarrhal metritis is here implied chronic metritis with catarrhal symptoms predominating.

ment of the uterus posteriorly from very slight exciting causes; and clinical observations, as well as pathological facts, render this explanation in the highest degree probable. Hence, therefore, the frequency with which early gestation and such lesions are associated, their influence in arresting fœtal development, and the fearful hemorrhage often attending long and labored efforts on the part of such a uterus to expel its contents.

The management of puerperal patients, too, ought not to be lost sight of in this connection, because, of all predisposing causes, there is none so likely to favor posterior flexion or version as incomplete metamorphosis and disintegration of uterine tissue after parturition; yet none, I feel convinced, more generally overlooked or disregarded. Thus, for instance, so long as the barbarous and stupid custom prevails, of forcing into the pelvis, by tight bandage and compress, a uterus as large as it is at four months of gestation, and, at the same time, hoping to aid the reparative powers, and counterbalance tissue-waste, by chicken-tea and panada, it is difficult to understand why, in such cases, some form of displacement should not be the rule, and a restoration of the uterus and adjacent organs to their normal condition the exception.

It is not my purpose at present, however, to discuss at length questions touching the pathology and treatment of these ailments, as the few cursory and general remarks here offered are intended solely as hints for reflection.

That there exist certain pathological conditions of the uterus marked by increased volume of that organ, and

a co-existent loss of the normal elasticity of its tissues, whether we choose to term the same *inflammation*, in the strict sense of the term, or perverted nutritive function, every observer must admit. It is also very improbable that any healthy uterus, gravid or otherwise, can ever become *retroflexed*, and never *retroverted*, except by mechanical pressure or traumatic influences. Consequently, and as there is no malady to which females are more subject than *chronic metritis*, this condition should always receive our first and most careful attention.

Finally, and in connection with this part of the subject, I may remark, that as dilatation of the os internum is a primary and essential step in commencing the topical part of our treatment, and as it is often impossible to insert a sponge-tent beyond the cervix, I have found those formed out of sea-tangle invaluable, as, when inserted once or twice, there is no difficulty in using the larger kind made of sponge, if deemed necessary. *Nevertheless, it is worse than folly to hope for any permanent benefit from topical measures merely: and, on the whole, constitutional treatment, and a strict observance of hygienic rules, are not only absolutely indispensable, but without them every other means will avail nothing.*

Before concluding these remarks, it may not be out of place to call your attention to certain instrumental aids devised for the purpose of facilitating operations within the vagina, and of the value of which I have been convinced by practical observation.

One of these (Fig. 5), is a delicately constructed vul-

sellum, or double tenaculum spring forceps, devised for grasping, and *retaining or dropping at will*, any portion or point of mucous membrane desired to be removed.

Fig. 5.

The perplexing annoyance so often experienced in laying hold of small points of membrane, and the difficulty of retaining the same by the aid of a tenaculum, have often been noticed and complained of by others as well as myself. The latter obstacle was at one time supposed to have been overcome, in some measure, by the ingenious contrivance of Dr. Perry, in having the tenaculum barbed. However, as tissues raised and held by this instrument could not be so easily unhooked, though often necessary, its utility was thus much impaired, and the advantages which it seemed at first to offer have never been generally recognized in practice.

The practical value, therefore, of the little instrument here exhibited, consists in enabling the operator, with the greatest possible facility and precision, not only to take up the most minute point of membrane and hold it firmly, but also to release it at pleasure.

I desire, also, to call your attention to a modification of the curved scissors originally devised and used by Dr. Emmet, and of which a specimen is here exhibited. (Fig. 6.) The objects attainable, and the many advantages afforded by this improvement, must

be apparent, even to those who have had but ocular experience in vaginal operations.

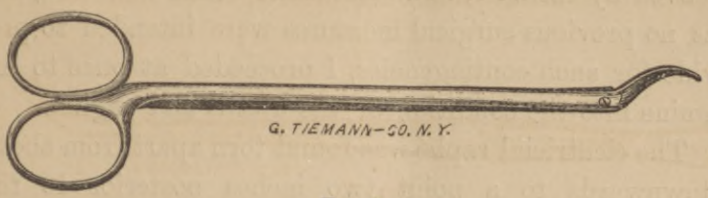

Fig. 6.

Of these, but two may be noticed; first, owing to the reduced size of the instrument, it can be used where the larger kind could not possibly be made to open and close; and secondly, on account of the convex side of its outer blade being thin and flattened laterally, we are enabled to apply its cutting edges to an almost level or flat surface.

Supplemental History of the Case of E——.

This patient having quite recovered, and being able to exercise freely without the slightest inconvenience, further than that caused by her femoral hernia, was permitted to leave the hospital. She returned, however, in a few days, suffering intense pain owing to complete retention of urine. She informed me that the previous day, while descending a flight of stone steps covered with ice, she slipped and fell heavily, causing great pain in the lower part of her abdomen and back, with great desire but total inability to pass water. *No urine had been voided for some time before this accident,*

and none up to the time of my seeing her. Not less than from six to eight pints of this fluid was now removed by catheter, and immediate relief followed, but as no previous surgical measures were intended to provide for such contingencies, I proceeded at once to examine into the condition of the uterus and vagina.

The cicatricial raphé was found torn apart from above downwards to a point two inches posterior to the meatus, and in its stead was a cystic hernia which must have been, to a certain extent, strangulated during the attack of retention, owing, principally, to the firm and unyielding edge of that portion of the artificial raphé not lacerated.

The uterus, though *slightly* prolapsed, showed no tendency to backward version, and there was a very marked decrease in its volume as compared with that noticed at previous examinations.

In the course of a few days she seemed to have entirely recovered from the effects of her injury, and the usual steps were taken to prepare her for

A SECOND OPERATION.

An elliptical surface, extending in length from the utero-vesical angle to about an inch behind the meatus, was entirely denuded, care being taken to remove all cicatricial tissue, including that part of the raphé unaffected by the late accident. The surface, thus prepared, was now turned in, and the edges united in the usual manner by silver sutures. On the twelfth day the sutures were removed, and the parts found to be firmly and, it is to be hoped, permanently united.

202 Clinton St., Brooklyn, N. Y.
March, 1869.