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TREATED BY SHORTENING OF THE ROUND LIGAMENTS,

WITH REMOTE RESULTS.

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SIX CASES OF UTERINE DISPLACEMENTS TREATED BY SHORTENING OF THE ROUND LIGAMENTS, WITH REMOTE RESULTS.[1]

BY CHARLES P. STRONG, M.D.,
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THE operation to which the attention of the Society is invited this evening ranks as a comparatively new one, and has not, as yet, a definite value assigned it; a result largely due to the insufficient lapse of time that has been allowed between the performance of the operation and the reporting of the cases. It has its earnest advocates and equally vigorous opponents. I do not propose to burden you with anatomical details or facts, except such as have arisen in my own experience and the deductions which I have drawn from my own series of cases.

To avoid repetition I will give in detail the procedures I have followed in all my cases. I have aimed to make the operation as thoroughly aseptic as a laparotomy. I make an incision directly upon the spine of the pubis and locate the external opening of the inguinal canal, clearing away the edges of the ring, raise the little mass of fat lying just inside, and, separating it by director and knife from the sides of the canal, draw it out until the round fleshy-looking fibre of the round ligament appears; exercising great care not to separate the proximal end of the ligaments from its fastenings. The fullest development of the ligament is not reached until an inch or more is drawn out. I free two or three inches of the ligament in this manner, handling it with great care and similarly treat the ligament of the other side. An assistant then lifts the

[1] Read before the Obstetrical Society of Boston, January 13, 1888.

uterus, vaginally, to its proper level and position, and any further slack of the ligaments is drawn out, and secured to the pillars of the ring by fine silk sutures.

The surplus mass of the ligaments is then folded upon itself and packed away, forming a plug in the ring, and the external wound closed without drainage. Dry occlusive dressing is applied, which is left undisturbed a week. A support inserted that will retain the uterus in its proper place and take all strain from the ligaments. The patient kept quietly in bed for two weeks.

Case I. Mrs. C., multipara, forty-two years old. The patient had been under my care since 1882 with rectal disease, which I found to be due to prolapse of the uterus, and temporarily remedied by pessaries. The uterus, which measured three-and-one-half inches, was anteverted, and so imperfectly sustained that any support that prevented its sagging between the lateral bars was necessarily of such size or shape as to incommode the patient and not infrequently cause erosions in the vagina. When wearing no support, the patient complained of constant pain through the rectum being often confined to bed by it. The first of August, 1886, I operated in the manner described above. Three-and-one-half inches of ligament were drawn out and secured on each side. There was no material difference in the size of the ligaments. A suitable pessary was adjusted, which was worn two months without inconvenience, then permanently removed.

The patient has been examined from time to time, the last examination being made January, 1888, one year and five months from date of operation. I find the uterus occupying as high a place in the pelvis as immediately subsequent to the operation. The patient is cured.

Case II. Miss K., age twenty-eight, single. Chronic

retroversion and retroflexion without adhesion. Symptoms: Backache and pain in both iliac regions; inability to stand. This patient had been under my observation for three years, during which time she had worn various pessaries, each of which afforded relief, but each of which also caused erosions in the posterior cul-de-sac of the vagina so that their use was intermittent and unsatisfactory. I operated in April, 1887, in the usual manner. There was a great deal of difficulty experienced from the thickness of the abdominal walls. I find in January, 1888, the uterus in perfectly normal position. The patient has been working as cook in a large hotel, and has not the slightest return of her old symptoms.

Case III. Mrs. S., aged forty-five years, multipara. Referred to me in May, 1887, by Dr. W. L. Richardson. She had prolapse, the cervix just appearing through the vulva; areolar hyperplasia of uterus; and bilateral laceration of the cervix; rectocele, and cystocele of small size.

The symptoms were backache, attendant upon walking. I first repaired the cervix and on June 1, 1887, the eighth day subsequently, operated as described above for shortening the round ligaments. On the first of January, 1888, I found the uterus in its normal position and decreased in size to less than three inches. There was no rectocele, very slight cystocele. No longer any complaints of pelvic symptoms.

Case IV. Mrs. S., aged forty-five, referred to me by Dr. W. L. Richardson. Procidentia, lacerated cervix, rupture of perineum through sphincter, and of recto-vaginal septum. Rectocele and cystocele. The cystocele was covered by an immense ulceration from friction between the thighs.

I repaired the cervix and perineum in April, 1887, keeping the patient under observation for two weeks

after she was about. The uterus stayed nicely in place, but in May she returned with procidentia as complete as before. The newly-made sphincter was perfect, but the so-called "perineal body," had completely flattened out, July 4th I operated for shortening the round ligaments. Seven inches of ligament on each side were drawn out before the uterus was fixed in its proper position. The rectocele disappeared, but the cystocele though improved, was not removed; on separating the vulva, a knuckle of the anterior vaginal wall was seen protruding. The patient was examined at intervals of a month with uniformly satisfactory results. The middle of December the uterus was found perfectly in place, the cystocele unchanged. Six-and-a-half months having now gone by, during which the patient had performed the usual household tasks of a poor woman, I felt justified in considering the operation a success, but to avoid any possible error, on January 2d, I again examined her and found the position just as bad as before, the uterus procidented; lying entirely outside the vulva, with a large ulcer upon it from friction. The patient said it came down without warning, and not in consequence of any unusual strain, within a few days of her previous visit.

Case V. Mrs. M., aged thirty years, multipara. Retroflexion and retroversion of uterus, prolapse and enlargement of right ovary, prolapse left ovary. Parametritic inflammatory adhesions. Symptoms: Backache, constant bearing-down pains in the pelvis that prevented locomotion. Recurrent attacks of pelvic inflammation.

The patient had been under my care for more than a year, during which time she had the routine treatment, including many and various-shaped pessaries, which rendered her condition somewhat more endurable than when they were not worn. But the ovaries

were an obstacle that prevented constant use of any pessary. From my notes, I find that no one form of support afforded relief beyond the period of one month. She was desirous of any operation that afforded a hope, however remote, of relief.

In the operation, performed June 28, 1887, I had the pleasure of assisting Dr. H. H. A. Beach, through whose courtesy I include the case among my own, as, except the immediate operation, the patient was entirely under my charge. The operation was performed in the usual manner, except that the two incisions were prolonged until they met in the median line, just above the pubes, and the ligaments were brought across the space, thus exposed and stitched to each other. The patient has been greatly relieved, not cured, nor do I expect her to be until the inflammatory exudation on the right is gone. All she suffers from now is pain of a neuralgic character, which affects the right side only. She takes plenty of exercise, and is vastly improved in general health. Anatomically, the operation has been a success. The uterus is in normal position, the ovaries are no longer prolapsed, and there has been a diminution of, at least, one-half in the enlarged ovary. The patient was examined the last of December.

Case VI. Mrs. R., age, sixty-eight; multipara. Procidentia, uterus between the thighs, and ulcerated; rectocele and cystocele. Symptoms: She declared the procidentia was brought on by falling down stairs, and, as she had visions of securing damages, I have attached no value to subjective statements.

I operated November 1, 1887, in the usual manner. An abdomen, pendulous with fat, added greatly to the difficulty of the operation, and the ligaments were unusually adherent to the walls of the canal. Convalescence was modified by the patient removing the dress-

ings in a few hours, and rubbing her dirty hands over the wounds, and by daily repetition of the offence, so that, for the only time, I failed of complete union by first intention. Every stitch-hole was an outlet for pus; also, the patient got out of bed and walked about at the end of a week, and was thoroughly unmanageable. Still the ligaments held, and when I examined her, a week ago, the uterus was held high up, and then, two months after the operation, seemed firmly in place. With the vulva opened, expulsive efforts showed cystocele and rectocele still present, but not protruding.

No. of case.	Disease for which Operation was Performed.	Immediate Result.	Remote Result.	Therapeutic Result.	Months Elapsed since Operation.	Length (inches) of Ligaments, Drawn out.
I	Anteversion, enlarged uterus, prolapse, with rectal symptoms	Good 1st intention	Good	Good	17	3½
II	Retroversion and retroflexion, without adhesion	Good 1st intention	Good	Good	8	3½ and 4
III	Prolapse, areolar hyperplasia of uterus	Good 1st intention	Good	Good	7	4
IV	Procidentia, rectocele and cystocele, hyperplasia of uterus	Good 1st intention	Failure (good for 5 mos.)	Failure (good for 5 mos.)	6	7
V	Retroflexion, prolapse, and enlargement of ovaries, parametritic adhesions	Good	Good	Good	6	3½
VI	Procidentia, rectocele, cystocele.	Good. Suppuration both incisions	Good	Good	2	3½ and 4

NOTE.—March 1, 1888. There has been no change in the position of the uterus in these cases, so that the "number of months elapsed" should now be 19, 10, 9, 8, 8, and 4.

The tabulation of these cases show that the two in which were backward, and the one of forward displacements, accompanied by various complications, adhesions, prolapsed ovaries, etc., have been cured by this operation. The one of prolapse of the uterus, unaccompanied by cystocele and rectocele, has also been cured.

The one of complete prolapse, with large cystocele and rectocele, although for a considerable time apparently cured, has proven since to be a failure. In this patient seven inches of the ligaments were drawn out on each side, and this suggests the explanation that possibly there may be an abnormal tendency for the ligaments to be elongated.

The one of complete prolapse, with rectocele and cystocele, that has had but two months of convalescence, is entitled to a very guarded prognosis as to cure, and I have advised operating upon these latter complications.

From my own experience, I think it may safely be said there is no difference in the size of the ligaments dependent upon age or child-bearing. There is often a considerable variation between the ligaments of opposite sides. I have preferred to use the redundant portion of the ligaments to plug the external ring, instead of removing it, for two reasons: to lessen any possible danger of hernia, and to ensure that the patient's condition shall be no worse than before, in case the ligament should break away from its fastenings. There is but little danger of its sloughing if care be used in handling it.

The operation is not one of so great difficulty as has been claimed. Care in determining the landmarks, and delicacy of touch, rather than of sight, are its particular requisites. Of its dangers, the first is pyæmia, which appears as the one cause of mortality,

and naturally suggests the question of sepsis; the other is of herniæ in the wounds, which, I think, the method of closing the ring by the superfluous ligament will decidedly lessen. So far, I have escaped both accidents.

As yet, I have subjected no patient to this operation until I have made a thorough trial of non-surgical measures for her relief and failed, but I feel sure that in certain cases in the future I shall operate much sooner.

Backward displacements of the uterus *which can be replaced*, even if complicated by adhesions or displaced ovaries, can by this means be cured, and our hospital clinics relieved of the large number of women whose treatment by pessaries is unsatisfactory both to themselves and us. It will be less often the operation is demanded by those who have time and money for other forms of treatment; but even among these will be found an occasional case where a prolapsed ovary or elastic adhesions interfere with the proper adjustment of a support.

I am not at all hopeful that in this operation will be found the cure for procidentia when there is a cystocele or rectocele of any considerable size, unless it be supplemented by the usual operations for these lesions. This conclusion is disappointing, and I trust future operations may prove it wrong.