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THE PALLIATIVE TREATMENT OF UTERO-VAGINAL PROLAPSE.*

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About eight years ago, in a paper read before this society, I advocated and still practice with marked success in suitable cases amputation of the cervix by galvano-cautery for uterine prolapse. I stated then that, after the removal of the cervix, my custom was to apply a firmly-rolled antiseptic tampon, by which the vaginal canal was to be kept on the upward stretch and consequently the stump well elevated. This tampon was to be removed by a careful rotary motion and a fresh one applied for two or three weeks, or until the completion of granulation and cicatrization.

I found that in cases so treated, the elevated position of the uterine body following such treatment—though noticed by mere accident many years previously—gave better promise of permanent relief than any plastic operation.

The appositeness of my allusion to this matter on the present occasion will be more apparent when I state that about the period referred to, and indeed for some time previously, my confidence in the utility of plastic operations for many of these displacements had been steadily on the wane. Thenceforth I had been hoping, from time to time, to devise some practically useful aid to palliative treatment, consistent with what I conceive to be the principles of uterine mechanics.

Besides, a large proportion of the victims of these infirmities—at least of those who came under my notice in hospital as well as private practice—manifested a very decided objection to experimental whittling of their sexual organs and not a few had already run the gauntlet at my own hands or in the service of some other hospital surgeon.

In 1887, therefore, I ventured—though I must say apologetically—to call the attention of this society to a form of pessary designed for the relief of prolapsus uteri, its action being mainly to counteract the sagging of the walls of the vagina. That instrument consisted of a properly curved Smith pessary, to which were added two lateral arched arms; and I still continue to use it with marked satisfaction in certain cases.

* Read before the New York Obstetrical Society, February 20, 1894.

Having at that period an experience of many years in the surgical treatment of ailments of this class by colporrhaphic operations, I felt then, as I feel now, that a due appreciation of our duty toward the victims of these infirmities, nay, the very nature of our humane calling, would seem to demand renewed efforts in the direction of palliative treatment.

I am well aware that the advocacy of palliative measures for the relief of utero-vesical prolapse is not quite in accordance with the trend of gynæcological thought and practice at the present epoch. In fact I am almost disposed to think that, in venturing to plead for any means other than surgical for the amelioration of such infirmities, one would risk the charge of being old-fashioned and behind the times if not utterly oblivious to the rapid progress and brilliant achievements in gynæcology during the last forty years.

I maintain however, with regard to palliative treatment of uterine and vesical prolapse through the instrumentality of pessaries or other mechanical aids, that it is as illogical, unreasonable and unjust to discredit or discountenance all such means because of their abuse as it would be to decry surgical interference because every tyro in gynæcology can not hope to imitate the unrivaled methods of Dr. Emmet or aspire to the genius of his revered associate pioneer in this branch of uterine surgery, the late Dr. J. Marion Sims.

I would have it understood, therefore, that while I question the permanent utility of many of the colporrhaphic operations, more especially some of European origin, I am far from discountenancing such practice in extreme cases by competent hands. For the poor toiling woman who has to support herself, and often a whole family, by laborious work while suffering from more or less complete procidentia, there is, of course, as a rule, no relief to be hoped for except through one or more skillfully performed operations. And yet even in such extreme cases I have often, by the aid of a pessary such as I now show, succeeded in maintaining the displaced organ within the pelvis, with great comfort to the patient, and enabling her to pursue her arduous labors with comparative ease and comfort.

During the current half of the present century, uterine flexions and versions and utero-vaginal prolapse would seem to have furnished an almost (if not quite) inexhaustible field for the display of mechanical, but too often misdirected, skill. Indeed, so numerous and varied have been the devices invented from time to time, but so often wholly incapable of effecting the object aimed at, nay, sometimes more potent for evil than in any manner useful, that gynæcol-

ogists of experience are apt to accept anything new or useful in this line with a shrug of incredulity. Nor is this to be wondered at when I, as doubtless also many of those present, reflect on the numerous and viciously constructed so-called supports which I have been called upon, from time to time, to excavate and which even now are daily resorted to with irretrievable injury to patients. Truly if the shades of the distinguished professors, Hodge and Meigs, could arise and see the extent to which the principles underlying their simple, safe and so often useful pessaries and rings had been ignored or tampered with, they would shudder at the perverse ingenuity of some of their successors and retire in disgust.

Dr. John Byrne's Cystocele and Prolapsus Pessary.

Thus, in the treatment of simple retroversion, how often do we not meet with cases of almost incurable retroflexion brought about by the injudicious application of a viciously shaped pessary or an anteflected uterus which some one has attempted to prop up by a contrivance which, even to contemplate, is suggestive of vesical destruction and which would bore its way through tissues as dense and resisting as cartilage! To the first of these evils may be attributed false teaching as to the manner in which a properly shaped pessary ought to, and as a matter of fact does, relieve rectal pressure and other disagreeable symptoms. As to the general run of anteflexion instruments in vogue, they are, to say the least (with one exception and that is the Gehrung), as useless as they are dangerous, and the principles on which they have been devised, though perhaps clear to their inventor, are certainly beyond my limited comprehension.

From these considerations, therefore, it is quite evident that to a lack of mechanical skill and a failure to duly consider and comprehend the relation of parts and organs involved, and the object and kind of mechanical treatment to be adopted for each particular case, is due the disrepute attached to the use of pessaries.

To the failure to obtain benefit from the many mechanical contrivances obtainable, especially for the relief of utero-vesical prolapsus, is doubtless to be attributed the favor with which numerous and oftentimes useful plastic operations have been viewed and resorted to in the last twenty years or more. During this entire period, in fact soon after the publication of Dr. Sims's bold but unsuccessful attempt

to excise the anterior wall of the vagina, I have conscientiously, and with as much skill and care as I am capable of, operated for the radical cure of these infirmities and followed as near as possible the lines laid down by our best operators, both here and in Europe. I have also had opportunities of noting the subsequent history and condition of patients operated upon by myself and many others, and I can safely say that in the very large majority of cases the relief obtained was not only inconsiderable and in unfavorable contrast with the sacrifice made but of very temporary duration. In making this declaration it is needless to remark, as I have already intimated, that I do not include in this qualified censure certain operations universally conceded to be essential and imperatively demanded as a *sine quâ non* to the success of any intravaginal mechanical device. Such, for example, as a very thorough colpo-perineorrhaphy extending beyond the plane of the levator muscles, as well as certain ingenious operations devised by Dr. Emmet for urethrocele, etc. But, from what I have observed myself, from the verdict of others of equal experience, and, without wishing to detract in the slightest degree from the great skill and operative dexterity of members of this society and others for whose versatile chirurgical ability I have the most profound admiration, I have long since, *i. e.*, during the period of six or seven years, ceased to urge or even encourage plastic operations for the cure of cystocele and prolapsus uteri merely.

A good perineal rest for the pessary here shown is all that I have found called for. I am also of the opinion that if it were possible to obtain all the facts touching these colporrhaphic operations, not so much as regards immediate results which, it must be admitted, are, when not "total failures," satisfactory and for the time attractive and promising, but if the condition of the parts at the expiration of a reasonably long period, say two or three years, are carefully examined, they would fully warrant the foregoing conclusions.

In this connection I may quote Dr. Emmet's statement in concluding his chapter on Prolapsus of the Posterior Wall of the Vagina. He says:

"In my practice previous to 1878, I found it necessary to operate on the rectocele and close the vaginal outlet of one hundred and fifty-four women of the number who suffered from the different degrees of procidentia. To impress this fact I will state that of one hundred and eighty women having rectocele, cystocele or complete procidentia, I diminished the vaginal entrance in addition to other operations in all but twenty-six cases. Where the operation was deemed not neces-

sary, it was found to be almost entirely among those who had cystocele only and in whom the change of life had already taken place. For over twenty years I have been in a position to observe the value of such surgical procedure devised for the relief of this class and to appreciate the changes brought about by time—the most valuable test of all. This experience has taught me that whenever the procidentia has been complete, if the change of life has not already taken place, the displacement will reoccur in every instance after the operations on the anterior wall, if the proper procedure on the posterior one has been neglected. With all the cases under my observation, where a support of the posterior wall was wanting, four years was the longest interval before the recurrence of the procidentia. I have found that even after carefully performing the final operations on the posterior wall and vaginal outlet the procidentia would soon return if the uterus was left retroverted unless it happened that the organ had become bound down by adhesion." (*Principles and Practice of Gynæcology*, 3d ed., p. 377, *et seq.*).

These statements are of great practical value and entirely in accordance with my own experience and observation. They more than emphasize the necessity for the use of some reliable mechanical support in all cases of procidentia, whether vesical or uterine or both, and however perfect the posterior wall may be naturally or as a result of colpo-perineorrhaphy. It is to be regretted, however, that still further information can not be obtained regarding the period of immunity from relapse after colporrhaphic operations. Indeed, statistical reports on this, as upon many other subjects, are few and unsatisfactory, so far at least as my opportunities of research have led me.

The reports of operations of this class and the papers read and discussed before the various societies, more especially in Germany, are singularly reticent on the subject; the leading object of members seemingly being to vie with each other for surgical notoriety and the distinction of novelty in the art and methods of vaginal whittling and stitching—for example:

A prominent exponent of radical operative gynæcology* and of course opposed to all palliative treatment, which he thinks "is universally admitted to be ineffectual," thus summarizes his exploits in sixty prolapsus operations, one only having died from septicæmia, viz.:

* A. Martin in *Amer. Jour. of Obst.*, vol. 13, p. 209.

"Fifteen times anterior colporrhaphy with three complete failures, four complete successes, and eight cures, but with subsequent stretching of the cicatrix; twenty times colporrhaphy after Hegar. Of these only twelve healed. Of these twelve, seven patients permanently improved; of the other five clinical patients, three have now, less than one year after, again symptoms of prolapsus. Five were operated after Bischoff's method; two were cured, but in three the flaps became gangrenous. After his own method five were operated upon; in one, no result was obtained; in three there was a complete cure, now of nine months' duration. In one the episiorrhaphy did not heal but the well-consolidated vaginal cicatrices have held the prolapsus back in a satisfactory manner up to the present time—over nine months."

In this not very lucid, if veritable, contribution to the science of statistics it will be observed that out of sixty operations forty-five only, exclusive of one death from septicæmia, are deemed worthy of special note. In other words, of the fate of twenty-three and one half per cent. of the whole number it would appear as if it were prudent to say nothing. There is surely no rule in the science of surgical record-making that dooms to utter oblivion patients who have been removed to another, if not a better, world; or, can the maxim of some statisticians, notably gynæcological, be "*de mortuis nil nisi bonum*"?

Possibly this problem may be solved in the hereafter, or at least a suggestion is pertinent to the effect that after all it may be that forty-six and not sixty patients have been subjected to sixty surgical efforts. Just here, however, we encounter other difficulties, for in the first series of fifteen patients, though three complete failures are admitted, there were four complete successes and eight cures! Here we have either a distinction without a difference or a distinction incapable of being distinguished. Again, in the second series of twenty patients, we are informed that not less than eight refused to heal. Now, why these eight perverse cases should be exempt from the plain designation of "complete failures" as well as their neighbors is also difficult to understand. But seven were improved, though five relapsed quickly so that in this batch there is not much to glorify over. In the third series of five, two are noted as cured; but in three of these five patients (that is, sixty per cent.) the flaps became gangrenous, so the subsequent condition of these patients can be imagined but can not be said to be "improved." In the fourth and last series of five, two were cured up to nine months, one did not heal, and one had "no result."

Reports like these, so strikingly ambiguous and misleading, smack so suggestively of the statistics of the vaginal hysterectomy for uterine cancer, one might almost imagine that the same evil genius presided over the compilers' deliberations in both cases; they are as difficult to interpret as the oracles of Delphi.

The following cases, each being typical of a class and taken from my record of a large number, will illustrate the benefits derivable from the use of my utero-vesical support.

Cystocele.

December 12, 1888, I was consulted by Mrs. D., a widow, aged fifty-nine, and the mother of five children; the youngest, twenty years of age. She suffered since three or four years after her last confinement with an involuntary escape of urine on much exertion, as in the act of sneezing or coughing, but withal a constant desire to urinate yet inability to completely empty the bladder. For the past two years she had noticed what she supposed to be her "womb coming down" when in the erect position or in the act of moving the bowels, which latter function has been difficult and incomplete by reason of "a feeling as if something were in the way."

On examination in the dorsal position, the anterior vaginal wall was observed to protrude to the size of a lemon, but the perinæum was fairly good. On introducing the finger it came in contact with the cervix uteri immediately but barely within the introitus and looking forward. Though the fundus was reflexed the entire organ was quite movable. A Gehrung pessary, such as I had been using for some years previously with excellent effect for cystocele and anteflexions, was applied. One week after, she reported that for some days following the application of the pessary she experienced the greatest possible relief so far as being able to retain urine.

On examination at the expiration of the week, I found that the pessary had turned about half round and was in a fair way of seriously injuring the soft parts. Having removed it, I sponged with a solution of tannin in glycerin, containing two and a half per cent. of carbolic acid and requested her to call in the course of a week when I hoped to have something more suitable to her condition. This was the first trial of a pessary in all respects similar to that now exhibited. Without going into details I will merely add that this patient has been wearing it constantly, with the exception of two weeks, up to the present time with perfect comfort. The cause of its suspension for the said two weeks will be understood when I state that this patient, con-

sidering herself perfectly well and free from all her former distress, did not call upon me or have the pessary removed for nearly eleven months. On removing it then I found the parts in a wonderfully good condition, all things considered, but deemed it best to sponge the vagina as before and substitute a firmly rolled tampon, soaked in an astringent and antiseptic mixture to be worn for forty-eight hours. This treatment was repeated several times during the two weeks when the pessary was replaced and has now been worn without change for four months.

Complete Procidentia.

Mrs. S., aged forty-one, stout, the mother of eleven children; the youngest now four years old. She says she has never had any trouble in her confinements and now menstruates regularly; that, except when in bed at night, her womb has been entirely outside for the past two years. In reply to my question as to the size of the protrusion she said: "It could only be compared to *a moderately sized football.*" A mere ocular examination sufficed to confirm her statement as regards the voluminous character of the protruding mass which consisted of the bladder, the uterus and ovaries and the entire rectal wall. Though the muscular tissue of the perineal floor had undergone atrophic changes, yet the mucous as well as the integumentary covering seemed to have escaped injury; the most depending part marking the seat of the cervix, was deeply ulcerated and, on being sponged, bled freely. The whole having been returned without difficulty, a utero-vesical support of unusually large size was temporarily adjusted, the antiseptic styptic freely applied to the ulcerated surface, and the patient directed to use a warm boric-acid douche twice daily for a week. At the expiration of this time she returned, stating that she never felt more comfortable in her life than she did then and hoped I might find it unnecessary to remove the support. To be brief—the course which I have always pursued in cases like the above was carried out in the present one.

1. For the first few weeks, or until the restored organs approach their normal size and weight through better return circulation, a weekly inspection is necessary.

2. A slight and gradual decrease in the size and, if called for, in the shape of the pessary, until the one for permanent use is decided on and,

3. A monthly inspection for two or three times, after which the patient may be allowed to remain away as long as she feels comfortable, but always with strict injunctions regarding antiseptic douching.