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THE TREATMENT OF A RETRO-DISPLACED ADHERENT UTERUS COMPLICATED BY PREGNANCY.*

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I have obtained such satisfactory results in the treatment of many patients suffering with the above complication, that I feel they would be received by the profession with interest; more especially at a time when the literature is so filled with operative procedures. Many patients will readily submit to treatment, though long, rather than undergo any severe operation, such as would necessarily be indicated in a case of adhesions surgically dealt with.

Many years ago it occurred to me, that abortion could be prevented in the retro-displaced adherent uterus, if treatment was instituted early enough, in properly selected cases. It is, therefore, my purpose in this communication to report my experience and to cite a few illustrative cases which have come under my observation, in support of my views on the subject of the treatment and curability of this complicated condition. In prefacing my remarks I hope to be correctly understood, as there seems to be some diversity of opinion regarding the ultimate results of retro-position with adhesions of the uterus.

This complication is by no means a rarity; on the contrary, it has been my experience to meet with it quite frequently. The fact that this complication exists proves beyond a doubt that adhesive pelvic peritonitis, with its sequelæ, may occur without complete destruction of function of the tubes and ovaries, aside from the existence of the pathological, abnormal position of the uterus.

CASE I.—Mrs. B., native of Germany, twenty-six years old, consulted me in January, 1887, on account of recurrent miscarriages. She

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had been married four years and a half, during which time she had had one child and three miscarriages; the latter being in succession, near the third month, and occurring during the past two years. Her health had always been excellent until the birth of her child, one year after marriage. The delivery was attended by a midwife, who removed the placenta in pieces; which the patient thought caused all her trouble, as she had fever and pain during a long convalescence and never felt the same nor well afterward. Menstruation has been fairly regular with profuse flow for ten days, attended by pains in the back and sides —more especially the right side of the abdomen—during the intervals between the miscarriages. The last period was April 1, 1887, and in May the patient began to think she was pregnant, which I corroborated by a digital examination which showed, in addition, a retroverted uterus—with firm posterior adhesions fixing the fundus below the promontory and within the hollow of the sacrum. To the right, and within the broad ligament, a marked thickening was readily felt. There was some descent and the cervix was lacerated. The fundus was perceptibly enlarged, presenting all the characteristic signs of early pregnancy. In spite of my endeavors to alleviate the pain and elevate the fundus uteri by local treatment, the pains continued to increase and finally terminated in abortion in July, the patient being unattended by any one. Some weeks later she returned to me with a marked endometritis and a boggy exudation in both broad ligaments. I again placed her on local treatment of glycerin tampons, occasionally painting the vaginal vault with tincture of iodine. In the following October I curetted thoroughly with the sharp curette, packing the uterine cavity with iodoform gauze, endeavoring at the same time to restore the uterus to its normal position, but without avail. Menstruation, however became normal, lasting only four days, and the exudation cleared up considerably. In January, 1888, the existence of early pregnancy was again discovered and the posterior adhesions were noticeably relaxing. Iodoform gauze saturated in glycerin was substituted for the cotton tampon and packed about the uterus, putting the adhesions on the stretch, and were allowed to remain in position three to six days with marked benefit. After two weeks' treatment, a Thomas-Cutter pessary was employed, with most excellent results. The adhesions separated sufficiently to allow the fundus uteri to become disengaged and be lifted out from under the promontory of the sacrum, and a Mundé bulb pessary was substituted to hold it in position.

At the time of separation of the adhesions, there were manifesta-

tions of expulsive pains and a slight sanguineous discharge, which was controlled easily by the fluid extract of viburnum prunifolium in ʒ ss. doses, repeated hourly.

The pessary was removed at the end of the fourth month of gestation, as its employment was no longer required, and pregnancy progressed normally and uninterrupted to its end.

On September 14, 1888, the patient was delivered of a healthy child of about nine pounds and a half in weight, and convalescence was normal.

Twelve days after delivery the uterus was found retroverted and was replaced, being held in position by the bulb pessary formerly used. After the expiration of six months treatment was found wholly unnecessary, as the uterine supports proved themselves amply sufficient, to retain the uterus in its normal position.

I have attended the patient in four confinements since that time, and there is not a trace of the old trouble remaining nor the slightest tendency to retro-displacement.

Case II.—Mrs. F. consulted me in the summer of 1888. She was thirty-one years old; had been married twelve years, giving birth to three children which were born, during the first five years of her married life. The last delivery, for some unknown reason, was a still-birth, resulting in ill-health and uterine disease, associated with sterility, for seven consecutive years. Menstruation had been regular every thirty-two days, varying in amount, but later only a scanty flow for one or two days. She complained of constant pains in the back and in both sides of the abdomen with impairment of locomotion. Constipation sometimes for a week, attended by severe bearing-down pain; severe frontal headaches, with occasional epileptiform convulsions when overtaxed mentally or physically.

An examination revealed a sharp retroflexed uterus with firm posterior adhesions; the ovaries were laterally displaced and enlarged, imbedded in an exudation, the right one being perceptibly the larger. The fundus uteri presented below the level of the cervical portion, forcing down the posterior *cul-de-sac* and resting on the rectum in the hollow of the sacrum. The uterus was hyperplastic and firmly adherent.

The employment of treatment twice a week, with glycerin tampons exerting pressure on the adhesions and exudates, soon produced evidence of improvement. The Thomas-Cutter pessary was substituted as soon as the point of toleration was reached but had to be discarded soon after, on account of the distressing symptoms produced;

not, however, before it had rendered good service. A bulb pessary was substituted for it and held the uterus at the same level, which was just beneath the promontory of the sacrum. While wearing the ring in this condition the patient conceived. On February 16, 1889, the diagnosis of pregnancy at the seventh week was made; her last menstruation appearing December 14th. The physical signs in this case differed materially, in that the elastic enlargement was perceptibly noticeable in the left tubal cornu of the uterus, causing me to apprehend a possible rupture of the Fallopian tube or of the structure of the uterus. At the tenth week of gestation, the uterus had assumed the natural symmetrical enlargement at the fundus so characteristic of pregnancy.

As gestation advanced, the uterus developed more than usual in the antero-posterior diameter, accompanied by increasing pain which was controlled only partially by the fluid extract of viburnum. On several occasions, morphine was necessary to give relief until the fifth month had been reached; whence the pains abated except at the approach of what would have been a menstrual period. The pessary was removed soon after the fourth month and the vagina packed with iodoform gauze, which remained five days in place.

As the uterus developed, the enlarged sensitive ovaries were very conspicuous on its sides, often giving rise to pains when accidentally pressed.

Labor occurred September 21st, marred by an epileptic convulsion; otherwise normal. The convalescence was similar to that of Case I. The pessary was found to be necessary for eight months after delivery; a perfect cure resulting.

Case III sought my advice for the first time in August, 1888. Mrs. K., thirty-two years old, married thirteen years, had had four children and five miscarriages; the latter occurring in succession after the delivery of the last child nine years ago. Since that time, she had suffered pains continuously. The labor was complicated by sepsis, with a slow convalescence. Each miscarriage seemed to add more to her misery. The last occurred three years prior to her visit to me at the third month of gestation, as the previous ones had. The uterus was found retroverted and adherent posteriorly, with a large bilateral rent with everted lips; there was also hyperplastic endometritis. The right ovary was slightly enlarged and there was laceration of the perinæum.

After a few months' treatment, preparatory to the repair of the cervix, the uterus was restored to the normal position and the patient,

without my knowledge, entered one of our large hospitals for operation. In March, 1891, two years and a half after the first call, she again consulted me with the following conditions: Laceration of the perinæum, retroflexion of the gravid uterus at the seventh week with posterior adhesions, enlargement of the right ovary with retro-lateral fixation of the tube and ovary and with evidences of the repaired cervix.

Under the same restorative treatment she progressed in the same manner as did the previous cases, giving birth to a child, November 25, 1891. Convalescence similar, except that an Albert Smith pessary seemed best suited to the case and it was discarded, after it had been worn six months, with no return of the displacement.

The diagnosis of retro-displacement complicated by pregnancy is a simple matter to those familiar with uterine disease, but unfortunately that does not apply to all in the profession. But to every intelligent doctor, with an ordinary "tactus eruditus," the conditions present, with few exceptions, may be clearly recognized. Any deviation backward of the uterus from its normal axis constitutes a retro-displacement. With these displacements, as a result of some prior inflammatory reaction, we have agglutinations of varying densities, which constitute adhesions. The principal cause, and probably the only one, is sepsis in some form; the natural tendencies being to abortion but, as in other instances, exceptions occur here also.

The diagnosis of adhesions is readily and positively proved by placing the patient on the left side or in the genupectoral posture with an attempt to replace the uterus by one or two fingers *per vaginam.* It will be found that, if adherent, the adjacent tissues posteriorly will move with it.

In favorable cases, the ovarian regions are free from complication. It must be remembered that impaction of the uterus must not be confounded with this condition. The differential point in impaction is the posterior or sacro-uterine ligaments constricting the fundus of the uterus between them and, when the attempt is made to elevate the organ, the ligaments stand out prominently on either side. Bimanually the uterus is felt between the palpating hand and the examining finger, eliciting the characteristic diagnostic sign of pregnancy, which is the elastic enlargement at the fundus uteri or its occurrence in either cornu, strengthened by collateral signs such as amenorrhœa, bluish discoloration about the cervix and the anterior vaginal wall, with acceleration of the pulse and the sympathetic morning nausea and vomiting. It must not be overlooked that in cases of

retro-displacement with adhesions, the development of the uterus is usually antero-posterior and lateral; not until the uterus is lifted above the promontory, does elongation occur. In the early weeks of pregnancy, the cavity of the uterus lengthens, about a fourth of an inch in the first two months. Hegar's sign, *i. e.*, a softening of the lower uterine segment,* is absent in many cases, due to the hyperplasia existing in many cases of displacement which softens very slowly.

Ovarian complications are readily distinguished by palpation and by exclusion, and the same may be said of tube complications. I do not wish to infer that every case of retro-displacement of the adherent uterus complicated by pregnancy can be cured, but, I do say, every case unattended by treatment will terminate in one of two ways: the first and most frequent is by abortion, the second, though rare, by the uterus becoming incarcerated. I have examined one such case, which refused advice or treatment and was lost sight of. The pregnancy had reached the fourth month.

The treatment of these cases depends largely upon the individual patient. Some tolerate more manipulations than others. This peculiarity, must be learned, in every case, by observation and trial.

It is very necessary to treat the patient at least twice a week, placing her on the left side with the index finger, (one finger is sufficient) used *per vaginam* and thus endeavoring to replace the uterus with as much force as the patient will tolerate comfortably; holding it in the newly obtained position with iodoform gauze, cotton or wool tampons, saturated in pure or borated glycerin, for one or more days. In course of time the patient becomes tolerant of sufficient interference to employ the Thomas-Cutter pessary which acts mechanically in the same manner as do the tampons, except more effectually and forcibly, toward separating the adhesions and restoring the uterus to a normal position.

The length of time necessary to continue its use varies in each case; usually from one, to six weeks is sufficient. As soon as the object is obtained for which the lever pessary is designed; it may be replaced with one of the internal pessaries, as the needs of the case seem to demand, which must be worn until such time that the uterus will be found too large to return to its retro-displacement. The end of the fourth month will be found, sufficient to insure safety against such a return in all cases.

In conjunction with the local and mechanical treatment, internal

* *American System of Gynæcology.* Mann, of Buffalo.

medication is of great importance to relieve the distressing symptoms arising from the physiological increase of the uterus, and the necessary devices for separating the adhesions.

The agglutinations in this complication seem to absorb or to separate more readily; possibly due to the fact that the pregnant condition may act a part, toward inducing absorption, aside, from its mechanical influence by the physiological increasing growth.

The nerve sedatives and carminatives display their influence and should be employed from the beginning, as soon as symptoms develop. The most valuable seem to be the viburnum preparations. Codeine and morphine should only be resorted to when other things fail to relieve pain.

In some cases, the iodides are followed by marked improvement. All cases are much benefited by the judicious employment of the chalybeates with strychnine in conjunction with laxatives. Gentle exercise in the open air is of the greatest importance; in fact, anything which tends to improve the general tone of the patient's physical and mental condition.

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