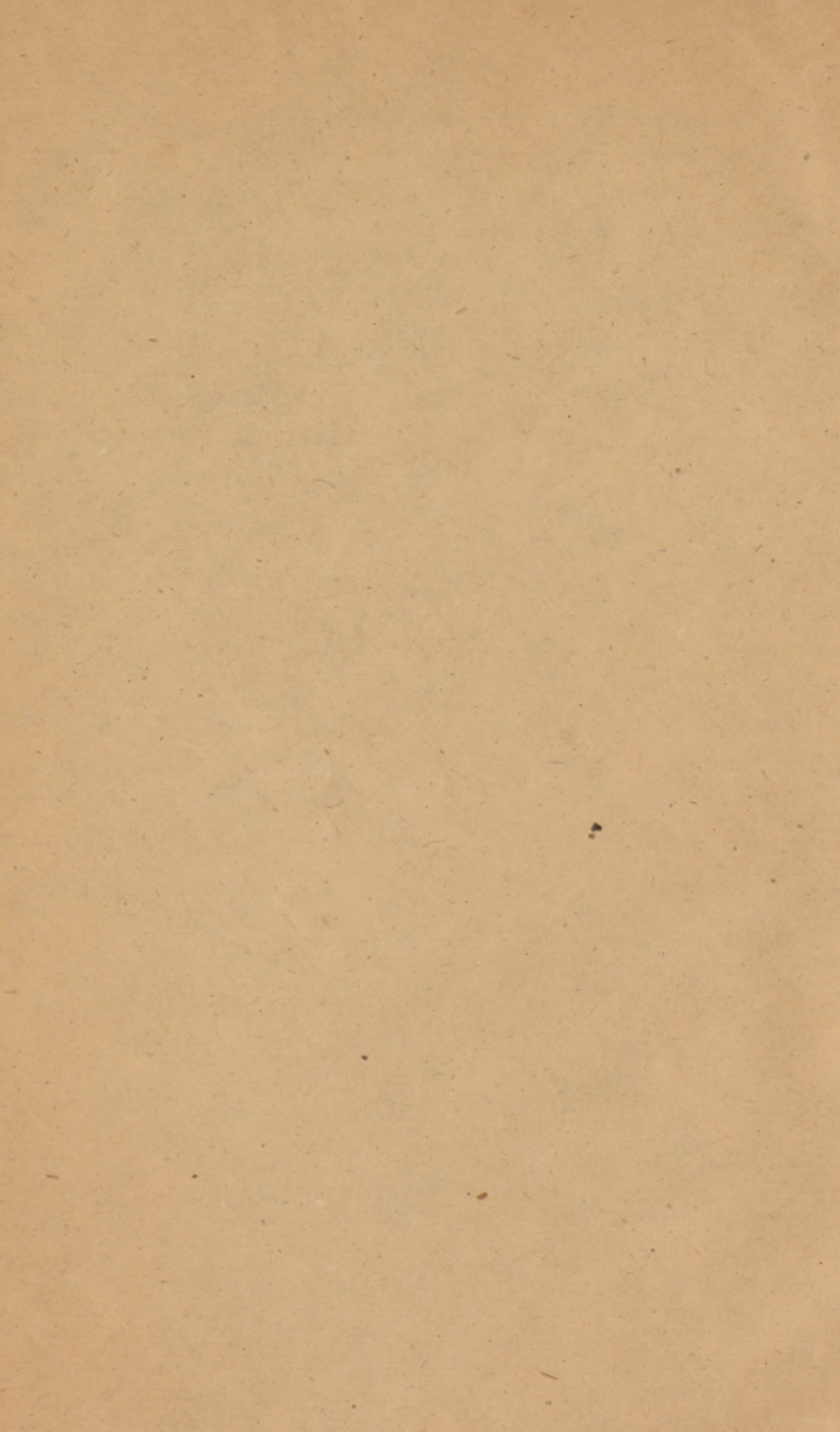


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*A new form of Intra-Uterine Stem Pessary, with remarks upon the general use of Intra-Uterine Stems.—By R. A. Kinloch, M. D., Charleston, S. C.*

The value of the intra-uterine stem in the rectification of versions or flexions of the uterus is perhaps not yet definitely fixed. Since the time when Velpeau, Valleix and Simpson experimented with this means of treatment, to say nothing of the period anterior to this, the opinions of the profession, as to its value and its danger, have greatly fluctuated. The sentiment of Dr. Robt. Barnes, perhaps the best modern authority upon the diseases of women, may be considered as approximating the correct view to be taken of this subject, and should be accepted in preference to either the enthusiastically favorable reports of modern writers, like Drs. Savage and Chambers, or the unqualified condemnation of so able a practitioner as Dr. Emmett.

"Before using any form of intra-uterine stem," says Dr. Barnes, when discussing the treatment of retroflexion, "it is desirable to ascertain whether the object cannot be attained without using them at all. The cases where it is necessary to use them are exceptional." Now, regarding these "*exceptional cases*," which such good authority recognizes, it must be admitted that the kind of stem employed is an important consideration. The condemnation of the instruments in general use must naturally have arisen from prejudice or from their proven inefficiency or danger, as illustrated chiefly in the use of unyielding stems with external attachments.





and the employment of these, too, without discrimination or adequate preparatory treatment. In other words the adverse decision as to the use of the stem emanated from the abuse of a principle.

We are of those who maintain that the effort to get rid of the evils which attach to intra-uterine stems should not induce us to discard them from practice. Rather is it incumbent upon us to develop their true value. As a step towards defining our position on this question we present the following affirmations:

1. All stems having external attachment or support must be discarded.

2. All of those rigidly fixed to vaginal frames so large as to restrict the movements of the stem, and thus prevent the proper physiological play of the uterus, are unsafe.

3. All of those whose lower extremity, or vaginal rest, is small, whether a ball, a disk or other form, and easily moveable in the vagina, are inefficient, because not capable of insuring the proper direction of the uterine axis, and are, besides, constantly liable to escape.

4. Those that are called "self-retaining" in virtue of a divaricated stem, are not always so, and we fear are liable to injure the uterine cavity because of their degree of expansive force. They are not suited to versions, for reasons urged in connection with the last class.

5. The simultaneous use of the Hodge pessary and the intra-uterine stem has been thought to overcome in cases of retro-version or retro and latero-flexions, many of the difficulties referred to as attached to the previous forms. "This *separate* mode of using" the two instruments, Dr. Barnes thinks "the safest and most satisfactory in its results." But it must be stated that the "*separate use*" necessitates, in the view of this able author, the employment of a divaricated stem, to which, as we have said, there are objections, on account of its elastic expansion when in the cavity.

6. The *connected use* of the Hodge pessary and the stem has been suggested and carried out after several devices by Dr. Graily Hewitt and others. The plan of Hewitt is by a hard rubber diaphragm, which bridges across the branches of the Hodge pessary, and serves to support and fix the stem. The rigidity of the stem, in this instrument, is an objection which we need hardly again urge. Very recently our excellent American authority, Prof. T. G. Thomas, of New York, has suggested the combined use of the two instruments—(there is here no actual *connection*, and yet the use of the instruments is not *separate* in the sense of Dr. Barnes)—without actually connecting them when *in situ*. The plan enables him to dispense with the self-retaining or divaricated stem. The instrument is figured upon pages 411 and 422 of the last edition of Prof. Thomas' admirable and now world-known treatise on the diseases of women. The Hodge pessary, or vaginal frame, is here bridged by a shallow vulcanite cup, which holds the ball that terminates the lower extremity of the uterine stem. The object is to permit the physiological movements of the uterus and, as said, to retain the stem. This instrument is complicated, but ingenious. We have no practical experience with it, but have no doubt of its efficiency in cases of flexions, for which alone, the author seems to have intended it. Theoretically, we believe that in cases of version, the shallow cup for holding the stem would be found inadequate to prevent the tumbling over of a heavy uterus. It may be said that the Hodge attachment would of itself prevent this in cases of retro-version. If so, we opine there would be no necessity for an intra-uterine stem, and the combination of the two instruments would be without object. We infer that Prof. Thomas has had but little experience with this instrument. He has generally been opposed to the use of the intra-uterine stem, and has apparently, in this last edi-



tion of his book, given it special attention in deference to the apparently growing favor, which it seems to have obtained with certain British authorities.

Some years since, it will be remembered by members of this body, I called attention to and exhibited a model of a pessary devised by myself, in which were combined the Hodge lever with the intra-uterine stem. I had adopted this after a good deal of reflection, and some experience with the use of intra-uterine stems. This experience began soon after my acquaintance with Prof. Simpson, made during a visit to Edinburgh, in 1855. Here is the original instrument of Simpson that I tested, as I also did the instrument of Valleix, having an external attachment. I cannot now fix the date of my earliest use of the Hodge pessary as the vaginal frame and supporter of the stem, but I am quite sure that the idea of combining the two instruments was independent of any suggestion. After numerous experiments and devices, I adopted the instrument which I now, after three years, present again to this body, and which, up to this time, I have not brought publicly before the profession, because preferring to test it by a larger experience. I am still free to admit that my experience in its use is not very large. The valued opinions of a few friends is my chief reason for here offering this paper, yet I may affirm that the last few years have confirmed me in my opinion regarding the advantage to be derived from the judicious use of uterine stems in cases of flexion, in troublesome cases of retro-version, and in some forms of dysmenorrhœa. With regard to ante-version, I have had scarcely any experience.

I now invite attention to my "*Elastic Spring Stem Pessary*," or the "*Buckle Pessary*" as it has been named by Messrs. Tieman & Co., to whom I am indebted for the finely executed drawings of the original instrument made by them. (See Figs. 2 and 3.) It is simply a union of the Hodge pessary, which is used as the vaginal frame and



support for the stem, and to assist, likewise, by its own action in supporting the uterus, with a hard rubber uterine stem two inches, or two inches and a quarter in length. The two instruments are connected by a delicate rubber cord, which is looped over the branches of the Hodge pessary, and furnishes an elastic support for the stem. I would here remark that any of the modifications of the Hodge pessary, as the Albert Smith, the Graily Hewitt, or the "Rocker pessary" will answer equally well for the purpose. The plan adopted for attaching the stem to the vaginal frame, with the rubber loop, is peculiar, and gives to the instrument a distinct and important action, from which, in some cases, it is thought advantageous results may be derived. The lower end of the stem is fashioned like a shirt stud, having a large and a small disk, with an intermediate neck. There is also a perforation in the centre of the lower disk. The larger disk is for the purpose of receiving or supporting the os uteri; the lower one to prevent the slipping off of the rubber cord.

After the rubber loop is slipped over the branches of the frame, the parallel cords are seized with the fingers and twisted to the necessary degree. The lower disk of the stem is then passed between the cords, mid-way between the branches of the frame. The stem is thus at once grasped by the cord, which secures it at its neck. If the cords have been twisted towards the upper cross-bar of the frame, it is evident that the elastic force, produced by the effort of the cords to untwist and resume their original parallelism, will tend to make the stem describe the arc of a circle and throw its upper, or free extremity, towards, or upon the lower cross-bar of the frame. The amount of this force will depend upon the size or strength of the rubber cord used, and the degree to which it is twisted. The advantage of this force, carefully regulated and gradually increased, I have verified in cases of retro-version where,

because of adhesions or contracted ligaments, the uterus at first refused to come up to its proper position.

By twisting the cords in the opposite way, towards the lower cross-bar, the direction of the force is so changed as to serve our purpose of treatment, in cases of ante-version. To prevent any tendency of the loop to slip up or down along the branches of the frame, the hard rubber or metal, constituting this, may be easily notched with a file, at the point desired. It is always within the power of the operator to adjust the force to a nicety, in accordance with the indication to be fulfilled, and also to fix the loop at any required portion of the branches of the vaginal frame. A very moderate force is what is advised, in most cases, generally only the degree sufficient to keep the stem in the direction of the proper uterine axis, and offer a minimum resistance to the tendency to displacement of the organ in the noted direction. The uterine sound, or repositor, must be used from time to time, to assist in the restoration of the organ.

To introduce the pessary, after due preparation of the patient, as explained below, it is best to employ Sims' speculum, and to have the assistance of a competent nurse or physician. This is, however, not always necessary. With a narrow vaginal frame, the introduction can be effected by the operator alone through an ordinary Nott's, or Smith's speculum, or even without a speculum, provided the operator is accustomed to this kind of manipulation.

To illustrate the introduction of the pessary, in a case of retro-version: First, seize the anterior lip of the uterus with a long tenaculum to steady the organ. Then pass a uterine sound to get a correct idea of the size and direction of the canal. The stem, which is now secured and kept down upon the upper cross-bar of the frame by a sound or stout wire, introduced into the perforation of the lower disk (See fig. 3)—is now advanced along



the vagina (as is also the frame, but to a less extent), made to traverse the os, and to securely engage in the uterine canal. The wire is now withdrawn, as the frame, pressed up higher and higher by the other hand of the operator, is finally adjusted with the cross-bar, occupying the posterior vaginal cul de sac.

While it is desirable, for facility of introduction, to have the vaginal frame as narrow as practicable, care must be taken that the length of this be well adapted to the particular vaginal canal. It should not be long enough to act, as a brace or prop, and thus endanger the integrity of the tissues of the vaginal cul de sac, and yet it should have sufficient length to prevent much to and fro movement.

In cases of anteversion, certain modifications of the manner of introducing the pessary will occur to any one familiar with uterine surgery, and need not be dwelt upon here.

In every case, but in flexions more particularly than in versions, preliminary treatment has to be instituted, and this I will now allude to in a few remarks upon

#### *The General Use of the Intra-Uterine Stem.*

After completing a rough sketch of this paper, my attention was called to extracts from an article by Dr. C. H. F. Routh, read before the Obstetrical Society of London, December 4th, 1874. The views of this author I find so nearly related to my own that it would be superfluous for me to dwell at length upon this subject. But as all the members of this body may not be familiar with these views, as expressed by the very able gynæcologist referred to, I may venture a succinct statement of the principles of the preparatory treatment I have commonly adhered to.

As already intimated, in the use of the stem I have endeavored to confine myself to such cases as *could not, in my judgment*, be managed by the more common means.

I have ever appreciated the necessity of getting rid of all inflammatory complications, and of at least moderating the more prominent nervous symptoms. All the functions of the female are looked to with the view of improving those that are faulty.

The frequent preliminary use of seatangle tents I insist upon, to inure the cavity to the presence of a foreign body. Often it is necessary to open the os by bilateral or other incisions. In flexions the canal must at times be straightened by preliminary incisions. The use of glycerine, cotton tampons, hot water vaginal injections, the frequent introduction of the uterine sound and uterine reposer, to aid in bringing the organ to a better position, applications of iodine or crude carbolic acid to the uterine cavity, are some of the means commonly resorted to.

When ready to try the stem in cases of obstinate version, I first use a simple stem that can be easily introduced and removed. This is not expected to be certainly self-retaining, but its position is maintained by tamponing the vagina, and keeping the patient at rest. Figure 1 represents one that is convenient. The stem is of hard rubber, like the one used in connection with the Hodge pessary; its base, a soft rubber ball. The ball is perforated by the lower end of the stem, from which the lower disk has been temporarily removed. After perforation, the upper and lower parts of the sphere are pressed together, and the lower disk of hard rubber again screwed on to the stem. The ball is thus converted into a hemisphere, so that it will be better retained by the vaginal walls. The stem is introduced by seizing the soft rubber hemisphere with a pair of long forceps, and carrying the whole instrument up through a speculum.

In dealing with flexions, I first use an elastic stem, made of a coil of fine wire covered with rubber, or a beaded self-retaining stem of soft rubber cord, perforated below to carry a wire (stem here shown as made



by Tieman & Co). Thus, there is no effort to straighten the canal too suddenly. Sometimes a seatangle tent precludes the necessity of using these flexible stems, or its use is a step preliminary to their introduction.

After two or three days, if the uterus tolerates the flexible stem, it is removed, and the uterine and vaginal canals cleansed with a weak solution of carbolic acid in glycerine. Now the elastic stem pessary is introduced, and kept in so long as it gives no discomfort or develops no alarming symptoms. The symptoms calling for removal of the stem are usually uterine pain, abdominal tenderness, bloody discharge, and sometimes gastric irritation. These I have met with only in exceptional cases.

The patient is constantly supervised and warned to give notice of any unusual occurrence; she is allowed only moderate exercise within doors, upon one floor. The stem is retained *in situ* for one week, if there be no urgent reason to the contrary. In cases of dysmenorrhœa, with or without flexion, the stem is kept in during the menstrual period. Upon its withdrawal, in cases of version, or version with flexion, the Hodge lever is used alone for one week or longer, if it seems in part to meet the indication, and then the stem is again introduced. The Hodge will not always keep the organ in position, but it will sufficiently elevate and support it so as to prevent us from losing, for the time, much that we have gained by the use of the stem.

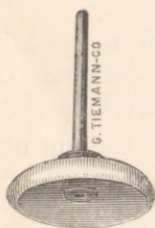
The modification of the Hodge, or of the Albert Smith pessary, that I have derived most satisfaction from, is one similar to that figured upon page 419 of Prof. T. G. Thomas' excellent treatise before referred to. The Albert Smith form of instrument is used, but the upper cross bar is bulbous, or of double thickness, so as not to cut the tissues of the vaginal cul de sac. It acts as a kind of crutch head for supporting the body of the uterus, disposed to retroversion. A heavy organ will often fall over the upper bar of the ordinary pessary,

while it will be well supported by the modified instrument referred to. This modification of the instrument, so far as the bulbous character of the upper bar is concerned, I imagined original with myself. The instrument was perfected for me by Messrs. Tieman & Co., some years since, after many endeavors, and sold as my pessary. Since the issue of Prof. Thomas' late edition, I have noticed a similar instrument figured, and called his "retroflexion pessary." The principle of the thick or bulbous cross bar is the same as my own. Regarding the other points, of length, breadth, curve, and theory of action of the instrument of Prof. Thomas, I am not prepared to express an opinion. Having very recently learned from my distinguished friend, that he had suggested the bulbous cross bar, and devised and used such an instrument long anterior to the beginning of my own experiments in this direction, it affords me pleasure to yield to him any credit for originality or priority that heretofore I might have been disposed to claim.

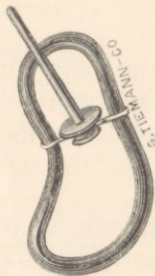
If upon withdrawing the internal stem, it is found that the Hodge pessary as modified will not support the uterus satisfactorily, it may, for a time, be dispensed with, and the vagina simply tamponned with cotton saturated with glycerine, or with a solution of per sulphate of iron. Rest is enjoined, and after a few days, the stem is again introduced. Perseverance is essential to success. In few cases of disease will we find it so necessary, during the application of our therapeutical resources, to bear in mind the old and safe motto—*festina lente*.

In conclusion, permit me to say that in a field limited to a private practice, experience is necessarily restricted, and while I have thought it not egotistical or improper thus briefly to give my views regarding a subject of great practical importance, it will be a source of no humiliation or disappointment if, upon a thorough trial of the means here suggested, a sound professional judgment should fail to sustain me.

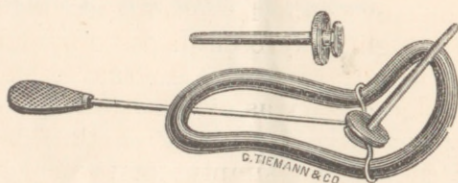




*Fig. 1.*



*Fig. 2.*



*Fig. 3.*

DR. R. A. KINLOCH'S STEM PESSARY.







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