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PRACTICAL FACTS AND OBSERVATIONS ON DISEASES OF WOMEN, AND SOME SUBJECTS CONNECTED WITH MIDWIFERY.

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(Continued from p. 554.)

ON PROLAPSUS UTERI, AND SOME AFFECTIONS WHICH ARE FREQUENTLY MISTAKEN FOR IT.

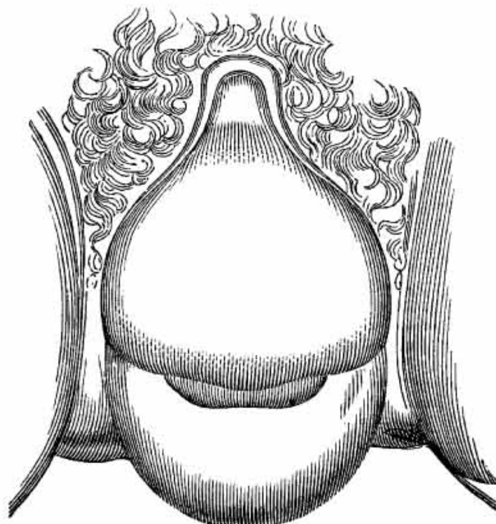
PERHAPS there is no uterine affection in which error in the diagnosis more frequently occurs than in prolapsus uteri. It often happens that prolapsus of the bladder, or of the posterior parietes of the vagina, or elongation of the cervix uteri, are mistaken for this displacement of the uterus; from the two former affections it is readily distinguished by the presence of the os uteri at the lowest part of the tumour. Prolapsus of the bladder and prolapsus of the posterior parietes of the vagina are as easily distinguished from each other; in the former we can readily pass the finger at the posterior part of the tumour, and feel the os uteri above it; in the latter we cannot pass the finger at the posterior part of the tumour, but we can readily do this at the anterior of it, and feel the uterine orifice. Although in cases of elongation of the cervix uteri the uterine orifice is situated at the bottom of the tumour, the cord-like elongated neck of the uterus may be readily distinguished by a finger passed into the vagina or into the rectum.

As long as the displaced uterus remains within the vagina it has been called prolapsus uteri, but when it protrudes externally, procedentia uteri; it is an affection of very frequent occurrence, more especially among the working class. It is stated by the late Dr. Hamilton,—"In the lower ranks in this country few women who have had a family attain the fiftieth year without being affected with some degree of the disease." (Practical Observations, part i., p. 6.)

Prolapsus uteri may be caused, first, by all those circumstances which relax the vagina, viz., fluor albus, frequent childbearing, excessive hæmorrhage, &c.; secondly, by whatever increases the weight of the uterus without adding materially to its size; thus it is often found connected with disease of the uterus; it occurs, too, when the uterus has acquired a certain size from pregnancy, or *is* diminished after labour to a certain size. A slight degree of prolapsus uteri is mentioned by some authors as one of the early signs of pregnancy. Professor Burnes has observed,—"About the second month of gestation the uterus may be felt prolapsing lower in the vagina than formerly; its mouth is not directed so much forward as before impregnation." (The Principles of Midwifery, by J. Burnes, C. M., p. 114, 6th edition.)

In the early period of pregnancy I have known prolapsus exist to such an extent as to render it necessary for the patient to recline on the sofa during the early months of every pregnancy, although at all other times she was quite free from prolapsus. (Case 1.) I have little doubt that prolapsus uteri is much more frequently the cause of abortion than is generally suspected. (Cases 2, 3.) Some women have a slight degree of prolapsus uteri at each catamenial period, producing pain in the back and groins, and a sensation of bearing down, a kind of dismenorrhœa, and the pain goes off entirely when the catamenia have ceased. In one instance which came under my care the lady suffered so much that I advised her to recline on the sofa for a week, from which she found immediate relief; and at all times when she commenced the reclined position at the beginning of each catamenial period, she never experienced pain. (Case 4.)

Thirdly, any force acting from above downwards may produce prolapsus uteri, as violent straining to evacuate the bowels, violent blows, or shocks. I have known three instances of ascites causing prolapsus uteri; in all these cases the vagina was first protruded, forming an anterior and posterior pouch, protruding through the os externum (as seen in the annexed cut), afterwards the



uterus itself protruded, so that it at length became a case of procedentia uteri; the tumour was in all these cases of great magnitude, and when the woman was standing the os uteri was situated at the lowest part of the tumour. The operation of paracentesis was performed in these three cases, and when the pouch formed by the inverted vagina became emptied, the uterus regained its normal situation and remained there till the fluid again accumulated in the abdominal cavity.

I believe I was the first to point out ascites as one of the causes of prolapsus uteri, for, although Dr. Denman has related a case of prolapsus uteri connected with dropsy, his patient was affected with enlargement of the liver, and he attributes the displacement of the uterus to the disease of the liver. (My translation of the work of Boivin and Dugès, p. 44.)

Prolapsus uteri is most frequently brought on by sitting up too soon after confinement, especially when the patient has had frequent labours; in these cases not only is the vagina relaxed and enlarged, but the ligaments as well as that passage are relaxed and yielding; the uterus has not resumed its natural size, and it is heavier and not large enough to receive support from the bones of the pelvis.

In the slightest degree of prolapsus uteri the uterus will often be found to have descended but little, but the os uteri in these cases will be situated more backwards, and the fundus more forwards, than in its natural condition; in fact, so much so, that the os uteri becomes pressed close upon the posterior parietes of the vagina, so as to form a pouch at this point of the passage, and thus completely to obstruct the uterine orifice, and, as Mdme. Boivin has observed, become a cause of barrenness, although there are many cases on record in which conception has taken place where the prolapsus has been complete, and those patients have borne living children. (Case 5.) Sometimes this slight degree of prolapsus uteri gives rise mechanically to obstruction of the bowels and uneasiness in the rectum. (Case 6.) The uterus may continue in this situation, or sooner or later descend, by degrees, lower in the vagina, but as it descends the direction of its long diameter becomes changed, the fundus is thrown more backwards, and the cervix is directed more in front, so that the os uteri is now found in the axis of the vagina, and in this

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direction it continues to descend gradually, till it protrudes through the os externum; but previous to its complete escape from the vagina it not unfrequently happens, as Sir Charles Clarke has observed, that it lodges on the perineum, as on a shelf; at this time the tension of the ligaments and the dragging sensation, as well as other troublesome symptoms, are removed, and the patient thinks herself much better, when, perhaps, from some violent exertion, the uterus is dislodged, and protrudes gradually or suddenly (Case 7) through the os externum, covered by the inverted membrane of the vagina; the tumour which protrudes will be more or less of an elongated form, and of greater or less magnitude, according to the viscera which have descended with the uterus, and are contained within the inverted vagina. The bladder, the rectum, and sometimes a large quantity of the small intestines descend, thus giving the tumour more of a round form, and occasionally it becomes of an immense magnitude. Sir Charles Clarke has related the case of a woman who died in Kensington Workhouse, in which the tumour measured more than fifteen inches in circumference, and its length was six inches and a half. (Observations on those Diseases of Females which are attended by Discharges, part i., p. 125.)

Although there may have been a copious discharge just before the uterus had escaped through the os externum, and become an external tumour, the discharge now entirely ceases, but returns again when the uterus has been replaced a short time. An explanation of this circumstance, I think, may be found in the fact, that where mucous membranes, by prolapsus or inversion of organs to which they have afforded a lining, become coverings, and are exposed to the air, they not only change their physical characters, and obtain the appearance of skin, but their functions also cease, and they no longer secrete mucus.

It rarely happens that the tumour formed by the prolapsed uterus exists long without ulceration taking place. These ulcers of the inverted mucous membrane of the vagina are very superficial, and soon heal upon returning the organ to its proper situation; they are generally situated at the lowest part of the tumour and those parts of its surface which are most exposed to friction from the cloths, or irritation from the urine passing over them.

Women who have had a family are most liable to prolapsus uteri, but I have frequently known it occur to those who have never had a child, and even to those who have never been married. Dr. Elliotson, some years since, published an interesting case of prolapsus uteri occurring in the virgin state; and there is a case related by Dr. Monro, in his works, 1782, of prolapsus uteri occurring in a child three years old; there was, at the same time, a discharge of blood from the vagina. The swelling could not be returned, and the child died after some time. The author closely describes the prolapsed parts as he found them on dissection, and they are also delineated by a copper-plate. (Bichter's Biblioth. Chirurg., vol. vi., p. 664.)

This displacement of the uterus often materially affects the stomach, and causes a train of nervous symptoms of a distressing character. Whether the uterus be protruded through the os externum or not, the strength becomes reduced; indeed, where the prolapsus is incomplete the woman's strength is more affected than in the former case, for incomplete prolapsus is generally attended by a very profuse discharge, of a purulent appearance, which subsides when the uterus is completely protruded.

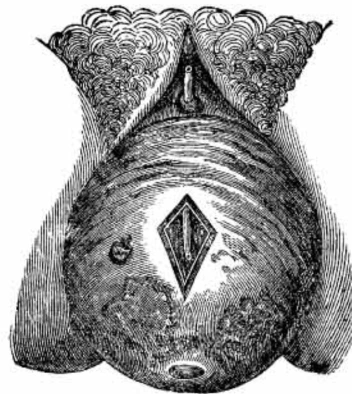
The local symptoms are a sensation of fulness in the vagina, and of something about to escape from this passage, a feeling of dragging and weight about the hips and loins, and considerable uneasiness about the groins. The tumour may press upon the bladder, or this viscus may be dragged down into the inverted vagina, giving rise to retention of urine or strangury. Sir Charles Clarke observes, that the strangury arising from prolapsus uteri may be distinguished from that which arises from other causes by its being removed when the patient lies down; or the uterus may press upon the rectum and cause tenesmus, or confined bowels. There is one symptom which sometimes distresses the patient greatly, a sensation of weight at the anus in rising up from a sitting posture, or walking; but this is much more frequently found in connection with procedentia of the posterior part of the vagina. Slight cases of prolapsus uteri are often mistaken, and the patient may be treated for a stomach complaint, without benefit, for many weeks, when she may be relieved at once by the reclined position, or by supporting the uterus.

A manual examination is absolutely necessary to enable us to form a correct opinion of the case, and this should be done after the patient has been up some time; if the case be recent, or only existing in a very slight degree, it will be necessary that she should have walked for a short time previously, and that the rectum and bladder should be emptied. The examination should be made with the patient either sitting upon the edge of a sofa or supported in bed by pillows, but what is far better, if she will submit to it, while standing.

In the natural situation of the uterus the os uteri can be just reached with a finger of moderate length, but in slight cases of prolapsus we can touch it by passing the finger half its length.

When the uterus has passed through the os externum the case is not easily to be mistaken.

In this affection, then, there is a tumour either in the vagina or protruding through the external parts; in the first case it is possible to confound it with congenital shortness of the vagina, but from this it may be distinguished by our being enabled, in prolapsus uteri, to push up the uterus, and thus lengthen the vagina, whilst in congenital shortness of this passage this cannot be done. When the prolapsus is complete, and the tumour protruding externally, it is often confounded with elongation of the neck of the uterus; from this affection it may be distinguished by our being enabled distinctly to trace the cord-like elongated cervix uteri with the finger introduced into the vagina or rectum, and should there be still a doubt about the nature of the case, and the woman be not pregnant, a bougie or female catheter may be passed into the os uteri, and it will be found to pass instead of two inches or two inches and a half, six or seven inches. The presence of the os uteri, at the lowest part of the tumour, will distinguish prolapsus uteri from inversion of the uterus. Compare the accompanying cuts;



in that which is intended to represent prolapsus uteri a bougie is passed into the meatus urinarius, and a portion of the tumour is removed, to show the situation of the displaced bladder. The os uteri, at the lower part of the tumour, will equally distinguish this displacement of the uterus from procedentia of the bladder and that of the posterior parietes of the vagina.

The tumour usually, in cases of procedentia uteri, returns into the vagina upon the patient reclining, or it may be replaced with the slightest pressure of the fingers; difficulty in replacing it is, comparatively, of very rare occurrence, but it is, in some cases, impossible to do so, and to attempt to do this without great care is attended with considerable danger. Sir Charles Clarke observes,—

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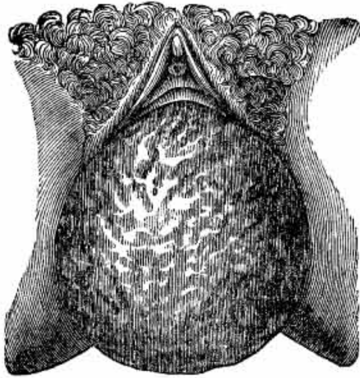
' Particular care should be taken to ascertain whether inflammation has, at any time, attacked the internal



parts of the tumour, because if this should have happened, and it the parts should have been connected with each other by coagulating lymph, the force which is necessary to accomplish the return of the tumour, may separate the adhesions, or tear the parts which are adherent, and the life of the patient may be brought into imminent hazard. Whenever, therefore, acute pain, which has been lasting, has occurred in the tumour, particularly when this has been accompanied by other marks of peritoneal inflammation, such as thirst, white tongue, small quick pulse, tenderness of the abdomen, and vomiting; no attempt should be made to replace the uterus within the body. (Case 7.) So, also, when the attempt is attended with great pain, all efforts to return the parts should be abandoned. Bands of organised coagulating lymph may compress some parts of the intestinal canal when the tumour has been reduced, and the patient may be exposed to all the hazard of strangulated hernia." (Observations on those Diseases of Females which are attended by Discharges, part i., p. 124, 2nd edit.)

Dr. Baillie observes,—" In inversion of the vagina and prolapsus of the uteri, if, after death, the cavity of the pelvis be examined, the fundus only of the uterus can be seen, with its appendages, very imperfectly, or the whole of the uterus is hid entirely; the bladder then appears to be in contact with the rectum. In this state of the uterus and its appendages I have known adhesions formed between them and the neighbouring parts. These must have rendered the reduction of the uterus and vagina to their natural situation very difficult, and, perhaps, till the adhesions were a good deal elongated, impossible." (Dr. Baillie's Morbid Anatomy, 4th edit., p. 419.)

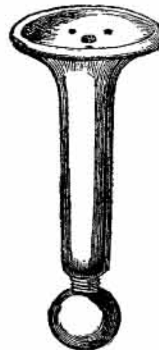
If it be determined that we should attempt the reduction of the tumour, the bladder and the rectum must be previously emptied, one by the catheter, and the other by an enema, and, as the bladder, in cases of this kind, is often situated within the tumour formed by the inverted vagina, the point of the catheter must be carried downwards, with the convex part of the instrument inclined towards the abdomen of the patient, or its introduction cannot be effected.

The rectum and the bladder having been emptied, the patient is to be so placed that the pelvis may be higher than the shoulders; the fingers and the thumb must be applied about the centre of the tumour, where the os uteri is situated, and gentle and careful pressure must be made.

The usual method of treating prolapsus uteri, when the tumour is reduced, or easily reducible, is to support the uterus while we endeavour to contract the vagina; the former is to be done by position, and instruments for that purpose; the latter object is to be obtained by attention to the general health, the local application of cold and astringents, and sometimes by an operation. We rarely succeed in cases of prolapsus uteri, of long standing, in obtaining a radical cure by any remedies, and it is only by an operation that we are to look for such a result; but, on the contrary, in recent cases, we may often expect it, and position, with the use of astringents, the cold hip-bath, and such constitutional treatment as will improve the general health, will often effect it without the use of pessaries; and, till a sufficient trial has been given to this plan, in my opinion, it is wrong to apply a pessary of any kind. The patient should rest upon a sofa, and use an astringent injection two or three times a day, or, what is far better, a piece of sponge, dipped in an astringent lotion, should be introduced into the vagina, and this sponge should be moistened, two or three times a day, with some astringent infusion or decoction. Care must be taken that the sponge be not so large as in the least degree to distend the vagina, and to prevent its becoming larger, after its introduction, it may be sewed in a piece of muslin; a cold hip-bath should be used, and the patient should continually recline upon the sofa. Should this plan not succeed after a reasonable trial has been given to it, or should the patient's general health become injured from want of exercise, support must be given to the prolapsed uterus by means of a pessary. Pessaries are made of different forms and of various materials, round, oval, ovoid, globular, &c.; the materials of which they are composed are hard woods, metals that will not readily oxidise, leather coated with wax, leather stuffed with horse-hair, Indian-rubber, &c.

Sometimes the vagina is so irritable, or this passage, as well as the uterus are so tender, that a pessary prepared from the materials which I have just stated cannot be borne; or the vagina may have been, by the great magnitude of the tumour, so distended, or may be so relaxed, that a pessary, either round, oval, ovoid, or globular, cannot be retained unless it is large enough to distend the vagina, and to do away with all hopes of a radical cure, or to exercise dangerous pressure upon the neighbouring organs.

Where the uterus and vagina are tender and irritable, the best pessary with which I am acquainted consists of a round piece of sponge, of a size adapted to the relaxed state of the vagina; this should be covered with a thin piece of Indian-rubber, or oiled skin, to prevent its absorbing moisture when in the vagina, and becoming larger. Where the vagina has been greatly distended, and remains so relaxed that a moderate-sized pessary is not sufficient to afford support to the uterus, but is forced out of the vagina, a pessary with a stem to it is to be preferred; for the last four or five years I have scarcely used any other in all cases of prolapsus uteri where position and astringents have failed to cure the affection, and where an instrument made of box-wood could be borne.



The stemmed pessary, which I recommend, is made of box-wood, and consists of a circular plate, the upper surface of which, upon which the uterus rests when introduced, is slightly concave; this is supported upon a hollow stem, about three inches and a half long; by means of a screw this stem admits of being made longer or shorter, as may be required. In almost all cases the concave plate upon which the prolapsus uteri rests requires to be a little more than an inch in diameter; thus the vagina becomes so little distended by this instrument that while it affords support to the uterus we may at the same time use the proper means to produce contraction of the vagina, and not entirely abandon the hope of a radical cure. This pessary may be supported by means of a T-bandage.

In cases of prolapsus uteri of long standing, which have resisted the usual method of treatment, and where the patient is past the period of childbearing, I have seen the operation which I am about to describe effect a radical cure. This operation was first proposed by Dr. Marshall Hall, and first performed by myself (Case 8);

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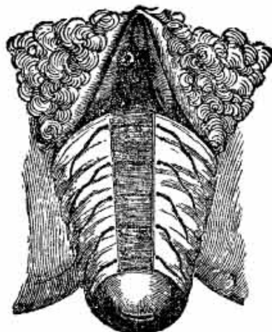
it has been since frequently successfully repeated on the Continent as well as in this country. It consists in obtaining the protrusion of the tumour as much as possible by the efforts of the patient; two parallel incisions are then to be made through the mucous membrane covering the tumour, from the sides of the os uteri, along the course of the protruding vagina, to the os externum; the portion of this membrane included between these two incisions is to be removed, leaving the space of an inch and a half in breadth, and the entire length of the vagina, completely denuded; a suture is then to be inserted near the os uteri, and others at short distances, extending to the os externum; these sutures must be successively tied, and as each ligature is tightened they will be found to be moving and supporting the os uteri upwards (see cut). Before this operation is



undertaken, we must be quite certain that we are correct in our diagnosis, that it is a case of prolapsus uteri, and not one of elongation of the neck of the uterus, for however successful the operation has proved in the former affection, it will, undoubtedly, not succeed in the latter. (Cases 9 and 10.)

(*To be continued.*)

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SUBJECTS CONNECTED WITH MIDWIFERY.

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(Continued from p. 673.)

ON PROLAPSUS UTERI, AND SOME AFFECTIONS WHICH ARE FREQUENTLY MISTAKEN FOR IT.

Case 1.—A lady at Kentish Town, about twenty-six, was subject, in the early period of each pregnancy, to prolapsus uteri, to such an extent that the os uteri was usually, after walking a short distance, upon a level with the os externum; this lady was quite free from prolapsus of this organ at all other times but when pregnant. In six successive pregnancies she completed the full period of utero-gestation, and the children were born alive. In the early months of each pregnancy she avoided exercise that might fatigue her, and reclined on the sofa frequently during the day.

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CASE 2.—A lady, about twenty-eight, who had resided some time in India, and was the mother of two children, the youngest of which was five years old, complained, after the birth of this child, of pain in the groins and back, with a sensation of weight in the loins, and of bearing down, with a frequent desire to make water; all these distressing sensations were increased, at all times, after a long walk, and ceased upon lying down; she frequently conceived, but invariably miscarried between the second and third month of her pregnancy, a period at which, during gestation, the uterus is found, naturally, situated somewhat lower in the pelvis than in the unimpregnated state. When I first saw this patient, she had been taking a longer walk than usual, and complained of being greatly fatigued by it; she had recurrent pains, commencing in the loins and extending down the thighs, a sensation of bearing down, and a frequent desire to make water. I advised her to take twenty-five drops of Battley's sedative tincture, and to remain in bed for a few days; afterwards to avoid, as much as possible, walking exercise, and to recline frequently during the day upon the sofa. This plan was pursued till quickening had taken place, and the uterus had become so large as to be prevented from descending. At the full period of utero-gestation this lady was confined with a living child, and, by adopting the same plan in each succeeding pregnancy, she has not since miscarried, and is now the mother of a large family.

CASE 3.—A married lady, twenty-six years of age, who had resided in the West Indies for some years previous to her marriage, became affected with a slight degree of prolapsus uteri, accompanied with pain in the back and groins, a sensation of bearing down, and a feeling, upon making an effort to evacuate the bowels, as if something were about to pass from the vagina; added to which there were strangury and leucorrhœa; all of these symptoms were aggravated by a long walk, and removed by reclining for a short time upon the sofa. She miscarried in three or four successive pregnancies between the second and third month; but, by avoiding exercises which fatigued her (especially walking), and frequently reclining upon the sofa during the day, in the early period of her subsequent pregnancies, she escaped abortion, and became the mother of three children.

CASE 4.—I was consulted by a lady, about twenty-six, who was married, but had no family; at each catamenial period she complained of pain in the back and groins, with a sensation of dragging and weight in the loins; upon standing, or straining to evacuate the bowels, she felt as if something were about to make its escape from the vagina; and there was a frequent and painful desire to make water; these symptoms went off when in bed, and returned upon rising in the morning; the catamenial discharge was natural in appearance, and unaccompanied by membranes or coagula. Upon lying down, at the commencement of each catamenial period, and continuing on the sofa for five or six days, she each time of menstruating escaped all these painful symptoms.

CASE 5.—Mrs. —, about thirty, who had had a family, upon leaving her bed after her last confinement experienced considerable pain in the back and loins, with uneasiness in the groins, bearing down, and a feeling, upon exertion, as if something were about to escape from the vagina; these symptoms were soon succeeded by the appearance of the uterus externally, which escaped from the vagina during a fit of coughing. In a few days the tumour became very large; when I saw it, twelve months afterwards, it was somewhat of a pyramidal shape inverted, with the os uteri at its apex; at night, when she went to bed, it receded into the vagina, and she became easy, but upon rising in the morning the tumour again protruded and the symptoms returned; she was now much distressed by strangury, from which she was only free when lying down. She objected to wearing a pessary, as she said it produced so much pain and uneasiness, and she preferred a cloth worn as a T-bandage; this was insufficient to keep the uterus in its proper situation, and upon any unusual exertion it escaped from the vagina, and passed through the os externum. Notwithstanding this she bore two children in three years. In the latter months of gestation this affection did not inconvenience her, nor did it greatly interfere with her labour, but at the earlier period of pregnancy she was greatly distressed by the procedentia uteri, and almost deprived of the power of attending to her domestic concerns, being obliged to lie down nearly the whole of the day.

CASE 6.—Dr. Marshall Hall was so kind as to take me to an unmarried lady, a patient of his, about twenty-six, she had been seen by an eminent surgeon, in Ireland, and was thought to have some disease of the rectum; the bowels were obstinately confined, and there was considerable uneasiness about this part of the intestinal canal. I found the uterus with its fundus more forward than usual, and the cervix so backward as to form a sort of pouch in the posterior paries of the vagina, so as mechanically to produce an obstruction in that part of the intestinal canal, and the os uteri was thus completely obstructed.

CASE 7.—Mrs. H., about forty, who has had a family, the youngest of which was four years old, stated that during a fit of coughing, something, which she supposed to be the womb, had suddenly protruded from the lower part of the body. She said she had been quite well since the birth of her last child to the present time, with the exception of a cough. She had leucorrhœa, which she first observed about a month ago. She now complains of pain in the back and groins, with a sensation of dragging in the loins, and a painful and frequent desire to make water; upon lying down at night, all these symptoms leave her, and the tumour recedes into the vagina, but descends immediately upon her rising. I found a very large tumour protruding through the os externum, and the os uteri was situated at the lowest part of the tumour, which left no doubt as to the nature of the case, that it was one of prolapsus uteri. A pessary was applied, and the patient has been comfortable ever since.

CASE 7.*—Mrs. S., a widow, aged fifty-five, has had a family, the youngest of which is fifteen. She has suffered many years with an irreducible procedentia uteri; the circumference of the tumour, at its thickest part, was fourteen inches and a half, and its length five inches; it was somewhat of a pyramidal form inverted, with the os uteri situated at its apex. With a view of reducing the size of the tumour, before attempting its reduction, I introduced a catheter and emptied the bladder, and in order to do this, as this viscus was contained within the tumour, it was necessary to direct its point downwards, with the convex part of the instrument turned towards the abdomen of the patient. She informed me that she had experienced several attacks of pain, at different times, within the tumour, and previous to these attacks she could easily push it up when she lay down. As I gave her pain in my attempts to return the tumour, although I made but slight pressure, I thought it right to desist, and recommended her to support it by means of a suspensory bandage. This woman died some years afterwards, with disease of the pancreas, and I had an opportunity of examining the contents of the inverted vagina; it contained the bladder, and a considerable portion of the small intestines, which were adherent by coagulable lymph.

CASE 8.—Dr. Marshall Hall's case, published in the "Medical Gazette" for November 26, 1831:—

"The subject of the case which I am about to detail, was a poor woman, whose bread depended upon the labour of her own hands. Her sufferings, from the prolapsed state of the uterus, were often extreme, and she was frequently disabled from engaging in her various occupations.

"For several years there had been complete prolapsus of the uterus; to this were also conjoined a partial descent of the bladder at the anterior, and of the rectum, formed into a pouch at the posterior part of this prolapsus. The os uteri protruded at least two inches beyond the os externum.

"It occurred to me, that if the canal of the vagina could be considerably, permanently, and firmly reduced in its diameter, the uterus would be supported in its place, and prevented from resuming its prolapsed situation; and that this might be done by removing a portion of the mucous membrane, along the anterior part, and by

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bringing and retaining the denuded surfaces in contact by successive deep sutures, until they should unite by cicatrix.

"This operation was attended with little pain; the only sensitive parts of the membrane being those near the os uteri and os externum.

"The patient was directed to keep quiet in bed. The bowels had been opened. An opiate was given. No pain or fever followed. In four or five weeks the denuded parts had firmly united, and shortly afterwards the ligatures came away.

"On examination, six, eight, and ten weeks after the operation, the os uteri could be just felt in situ, by the finger passed through the vagina; the vagina was firmly contracted along its whole course.

"The prolapsus of the uterus was thus completely remedied. The descent of the pouch of the rectum was lessened.

"P.S. The principle upon which this case was treated is illustrated by a fact, detailed to me by Dr. Holland, of Queen-street, May-Fair. A pessary, introduced in a young person, to support the uterus, subject to be completely prolapsed, induced great inflammation, this was followed by such firm contraction of the vagina that the uterus ever afterwards remained in its proper situation."

Case 9.—A person, about fifty, who was residing in London, and whose youngest child was about twenty-five, applied to me in consequence of a large tumour which protruded from the vagina, through the os externum; she had been afflicted with it for the last nine or ten years; it was somewhat of a pyramidal shape inverted with the os uteri, when she was standing, situated at its lowest part; its length was six inches and a half, and its circumference, at its thickest part, was about twelve inches. Although this tumour receded into the vagina by a little pressure with her fingers upon lying down, it instantly returned upon her rising, so that it rendered her incapable of attending to her domestic affairs. She had tried various kinds of pessaries, without relief, and it was thought by Dr. Marshall Hall and myself that an operation would be desirable; we both at that time supposed it to be a case of prolapsus uteri.

The operation was performed in the manner which I have described, but the tumour being large, it was thought necessary to remove a slip of the mucous membrane of the vagina covering it, from the posterior as well as the anterior part. As in the former case, there was but little pain produced by the operation, and very little blood lost, nor was there any untoward symptom during the healing of the wound; but the operation entirely failed. Soon after she left her bed, the tumour began to show itself, and in a few weeks it was as bad as ever. Upon a careful examination of the case, two months after the operation, it proved to have been a case of elongation of the cervix uteri, complicated with retroflexion of the bladder, and at the posterior part, the utero-rectal pouch contained a considerable portion of the intestinal canal.

Case 10.—This case was one in which the operation was performed by my friend Mr. Wallace. Hackney-road, and who has kindly allowed me to give the following account, from a paper read at the Hunterian Society, January 7 and 27, 1836; the subject of which was Mrs. B., a laundress, Susannah-row, Edward-street, Kingsland:—

"She has borne five children at the full period of utero-gestation, and has subsequently miscarried five times, which took place about the third or fourth month. Her last child, which was born at the full period of utero-gestation, was about six years old, from a short period after the birth of which she has been suffering from procedentia uteri, depending very low between the thighs, so as to render her wholly unable to perform those duties necessary for the support of her family. She has tried many different mechanical contrivances, with partial benefit. In consequence of this calamitous condition, I proposed to her the operation suggested by Dr. Marshall Hall, and performed by Dr. Heming, and on the 3rd of December, 1835, I performed it, in the presence of Drs. Marshall Hall and Heming.

"It is now seven weeks, and I have the pleasure to state that my patient has not experienced an unpleasant symptom, with the exception of once feeling a slight tendency to a descent of the uterus, arising from the expulsive efforts of hardened fæces, which had accumulated in the rectum, and a few days after, fearing a recurrence of this, I introduced a pessary, which she wore for about three weeks. She returned to her usual avocations. She was examined on the 25th of January, and it was thought by Drs. Marshall Hall and Heming, that the operation had been successful, and that the relief would be permanent."

It was found, at the end of a subsequent period, five or six months after, that the tumour again descended, and by an examination at this period, it is found to have been a case of elongation of the cervix uteri, which I do not doubt was the cause of the want of success in the operation.

Case 11.—Mrs. Young, about thirty-five, a widow with a family, applied to me, in consequence of prolapsus uteri; the tumour, which had appeared externally about two years, was very large, and the os uteri was situated at its lowest part. She experienced pain in the back and groins, and difficulty in making water, and frequent inclination to do so; all these symptoms went off upon her lying down, and the tumour usually receded into the vagina after she had reclined a few minutes. She held the situation of housekeeper, and was often obliged to recline four or five times a day, to enable her to perform her necessary duties. There was no discharge from the inverted vagina forming the covering of the tumour as long as it continued external. I passed a globular pessary, which I told her to remove every eight or ten days, and replace it; this supported the uterus comfortably in its proper situation, and she experienced no inconvenience now but an offensive discharge, which was removed by the continued use of an astringent injection and the cold hip-bath. I did not see this person again for five or six years, and she then informed me that she had not removed the pessary since I passed it!

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PRACTICAL FACTS AND OBSERVATIONS ON DISEASES OF WOMEN,

AND SOME

SUBJECTS CONNECTED WITH MIDWIFERY.

By G. Oakley Heming, M.D., F.L.S., Physician-Accoucheur to St. Pancras Infirmary and to the Western Dispensary.

(Continued from p. 697.)

ON PROLAPSUS UTERI, AND SOME AFFECTIONS WHICH ARE FREQUENTLY MISTAKEN FOR IT.

[The following lines were accidentally omitted in the eleventh case of Dr. Heming's last paper :—"The vagina was very tender, and I gave her considerable pain in removing the pessary; it was not replaced; she was advised to remain in bed for a few days, and to use an injection of cold water; the uterus has continued in its normal situation, and she has not experienced, since, any inconvenience from her complaint."]

PROCIDENTIA VESICÆ.

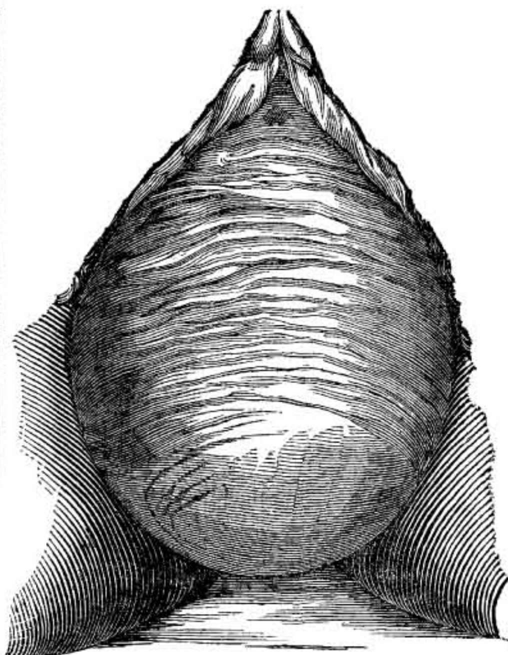
This affection is of much more frequent occurrence than is generally supposed, and it is, undoubtedly, often confounded with procidentia uteri. It is probable that Madame Boivin did not thoroughly understand this affection, or suspect its frequent occurrence, as she has given no delineation of it in her atlas, devoted only a few lines to the subject, and omitted two of its most characteristic symptoms,—"the pain referred to the navel, with sense of tightness there," and the "altered state of the os uteri." The diagnosis is so plain that it is only by a careless examination that we can account for its ever being mistaken for prolapsus uteri. The constitution is far less disturbed in procidentia of the bladder than in that of the uterus; the stomach does not sympathise with the protruded bladder unless there be a diseased state of the displaced viscus; nor is the nervous system so disturbed in this affection as in cases of prolapsus uteri. A mucous discharge usually attends this affection, which greatly varies in quantity.

Sir Charles Clarke has mentioned a symptom upon which he places great reliance, as regards the diagnosis; he observes,—

"The peculiar symptom which marks this complaint is a pain referred to the navel, with a sense of tightness there. This pain is the greatest when the bladder contains the largest quantity of urine, and as it parts with its contents the uneasiness diminishes, till, at last, when it is empty, or nearly so, the symptom goes off altogether."

The superior ligament of the bladder runs from the fundus of the bladder to the navel, to which it is attached, and, perhaps, an elongated state of the ligament (the remains of the umbilical arteries) or the effect produced by the dragging upon the navel itself, may account for this symptom."

On examination of the tumour, the os uteri will not be found at its lowest part, as in prolapsus uteri; it is still within the vagina; transverse rugæ may be observed, especially at the upper part of the tumour, and these are more or less marked, in proportion to the degree of distention of the bladder, and upon this also will depend the size of the tumour (see annexed cut), which will be comparatively small if the patient has just made water, although, as she cannot completely empty the bladder, the tumour will not entirely disappear; but any



doubt as to the real nature of the case, which may arise from this cause, may be at once removed by the introduction of a catheter (Case 1), which will not only remove any urine which may be contained in the pouch of the bladder, but we shall be enabled to feel the point of the instrument with the fingers applied to the surface of the tumour, the parietes of the vagina and bladder intervening. The tumour formed by procidentia vesicæ proceeds from the anterior part of the vagina, and the displaced bladder is covered by the anterior paries of that canal; so that we cannot pass our finger between it and the pubes to touch the os uteri, which is within the vagina above it. This orifice will be found to be distorted in a manner peculiar to this displacement of the bladder.

In the natural situation of the bladder the cervix of the uterus is strongly connected by a strong cellular membrane; in procidentia of the bladder of long standing, this cellular membrane and the anterior lip of the os uteri becomes very much lengthened. In this altered state of the parts, the os uteri is no longer found in the centre of the pelvis, but opens directly backwards, and lies in contact with the posterior parts of the vagina.

It is the posterior and inferior part of the bladder that descends in this affection; first a kind of pouch is formed, covered by the anterior part of the vagina, filling up that canal, till at length it protrudes through the os externum, and shows itself externally.

Case 1.—Mrs. —, fifty years of age, consulted me in consequence of a tumour protruding from the vagina, with which she had suffered for the last four years. Since the birth of her youngest child, which was seven years old, she has had leucorrhœa; she attributes the first protrusion of the tumour to a frequent and long-continued cough. Upon examination, I found a roundish tumour, about the size of a cricket-ball, proceeding by a broad base from the anterior part of the vagina, and protruding through the os externum; this was rendered very tense when the patient coughed, and there could be little doubt, from the sensation of fluctuation, that it contained a fluid, there was no opening to be felt in any part of it; I could not pass my finger into the vagina at its anterior part between the pubes and it, but I could do this at its pos-

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terior part, and feel the os uteri within the vagina just above it, with its anterior lip elongated, and the orifice itself distorted and opening directly backwards, and the os uteri lay in contact with the posterior part of the vagina. The upper and anterior part of the surface of this tumour was beset with transverse rugæ, which were more distinctly seen when the tumour was diminished in size by the patient making water; she was unable entirely to empty the bladder, and although the tumour was greatly diminished, it did not completely disappear, a pouch remained, containing a considerable quantity of urine, and when a catheter was introduced, and the urine wholly removed, there was a loose empty bag, which readily returned into the vagina by slight pressure with the fingers, and continued there whilst she lay down, but returned after standing for a short time. With my fingers applied to the surface of the tumour, whilst the catheter was in the bladder, I could feel the instrument, the parietes of the vagina and bladder intervening. This patient complained of a dull pain in the back, which was not relieved by lying down, and a pain, which greatly distressed her, between the umbilicus and pubes; this was most distressing at night, and was always relieved by emptying the bladder. The treatment which I advised was to keep the bladder as little distended by urine as possible, to wear an ovoid pessary, to keep the bowels relaxed by saline purgatives, and to use a cold hip bath; this plan was continued for a short time, the pessary was gradually reduced in size, and an astringent injection used, till at length the pessary was discontinued, and a firm roll of linen kept in the vagina in its stead; this also was discontinued after gradually diminishing its size, and the cold hip bath, with astringents only, were used. This patient got quite well, and as long as I knew her, which was for four or five years afterwards, continued so.

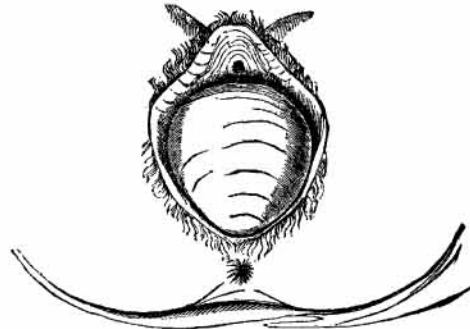
CASE 2.—A married lady, about thirty-six, observed a mucous discharge from the vagina, which continued for six months, without at all affecting her health; about two months before I saw her, she caught cold, which was attended with a very frequent cough, but which was not violent; to this she attributes an unpleasant sensation of fulness in the vagina, increased every time she coughs, and she says that at each fit of coughing she feels as if something were about to pass from her; she observed that the sensation was the same when she coughed, whether she were lying or standing, indeed, it was rather worse when lying down; she experienced considerable uneasiness between the umbilicus and pubes, which was greatly relieved by frequently emptying the bladder. Previously to my seeing her she had taken every morning a Seidlitz powder, and this she thought considerably relieved the pain between the umbilicus and pubes. Before I made an examination per vaginam I requested that she would allow the bladder to become distended. Upon passing my finger I found considerable fulness at the anterior part of the vagina, which became very tense when she coughed; it seemed to be caused by the posterior and lower part of the bladder protruding backwards into this passage; the os uteri was situated at the upper part of this tumour, with its anterior lip elongated. I had but little doubt but the tumour which I felt was the posterior and inferior portion of the bladder, and the correctness of this opinion was confirmed by the tumour being greatly diminished after she had made water. Her cough soon left her, and by astringent injections and saline aperients, and keeping the bladder as empty as possible, she entirely recovered.

PROCIDENTIA VAGINÆ.

Procidentia vagina, or "a relaxation of the posterior part of the vagina, so that this part is lower than the naturally defined edge of the perineum," is of far less frequent occurrence than either of the other affections which form the subject of this paper, or, perhaps, as Sir Charles Clarke has observed, "medical men are not so frequently consulted respecting this disease as concerning procidentia of the uterus or bladder, for it is not attended with the constitutional symptoms of the former, nor the local inconveniences of the latter disease." In these cases a pouch forms in the rectum, just above the upper edge of the sphincter ani, and this is often brought on by habitual costiveness; or hæmorrhoids, in many cases have been known to have the same effect; the os uteri, which is situated above the tumour, within the vagina, remains unaltered, but an occasional exception to this observation occurs; when distortion of the uterine orifice does take place, it is the posterior and not the anterior labium, as in procidentia vesicæ, which is elongated; the tumour is sometimes as large as a goose egg, and when the patient reclines, becomes somewhat smaller, but does not entirely disappear; the finger cannot be passed along the posterior part of the tumour to the os uteri, but this can be done in front, and there is a discharge of mucus from the vagina. This affection is often accompanied with a dull pain in the back, and there is almost always a distressing sensation of weight at the anus, especially upon rising from a sitting posture; it seems, on applying the fingers externally to the tumour, as if the pouch contained some portion of the intestinal canal, and I have no doubt that this has often given rise to the idea that the case might be one of vaginal hernia. I think this occurs from the circumstance of the two coats forming the pouch so readily moving over each; all doubt upon this point may be, at once, removed by passing the finger into the rectum, and carrying it forward into the pouch, which will be found filled with fæces.

The treatment should consist in emptying the pouch, and in keeping it empty, and at the same time, by pressure, and astringents applied to the vagina, to endeavour to obliterate it. Injections of warm water, thrown into the rectum, will usually be all that is necessary to remove the fæces which has already accumulated in the pouch, or it may be necessary to remove the contents of it with the finger, or the handle of a spoon. To prevent a re-accumulation, saline purgatives, or castor oil, may be taken, and an injection with warm water used every morning, and with a view of obliterating the sac, a globular pessary should be worn, the size of which must be gradually diminished; astringent injections should be thrown into the vagina, and the cold hip bath be used daily.

Dr. Marshall Hall saw the patient from whom the accompanying wood-cut was taken, and he suggested, that should the means recommended prove unsuccessful, the pouch might be contracted by removing a slip of the mucous membrane covering it from the vagina, and uniting the edges by the interrupted suture, as in the operation for the radical cure of prolapsus uteri.



CASE.—Mrs. Field, whom I saw at the Western Dispensary, was a married woman, about forty, she had a family, the youngest of which was eight years old; two years after the birth of this child, she began to experience a sensation of weight at the anus, especially upon rising from a sitting posture, and a dull pain in the back, but never acute, there was a mucous discharge from the vagina, and she felt, when she strained to evacuate the bowels, as if something were coming from this passage; about two years ago she perceived a tumour, somewhat larger than a hen's egg, projecting from the vagina. When she lies down, the tumour is rather smaller, but it never recedes into the vagina without pressure with the fingers; I could not pass my finger along the posterior part of the tumour into the vagina, but I could readily do this in front, and felt the os uteri distorted, with its lip elongated; but it was the *posterior* lip. It is not very

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common to find the os uteri altered in cases of procidentia vaginæ. Sir Charles Clarke, upon this subject, makes the following observations:—"No effect in this disease is produced upon the shape of the os uteri, because the cervix of the uterus is hardly at all connected to the rectum, and the cellular membrane between the vagina and rectum is very loose, and readily admits of the vagina projecting." (Observations on those Diseases of Females which are attended by Discharges, Part I., page 145.) On applying my fingers externally I thought I could distinctly feel that the tumour contained a portion of intestine, but upon introducing my finger into the rectum, and carrying it upwards just beyond the sphincter, and forwards, it passed into the pouch, which was filled with fæces. This pouch consisted of two coats, very loosely, if at all, attached and easily moving upon each other; the anterior, or external coat, was formed by the posterior part of the vagina, whilst the internal or posterior coat consisted of the anterior part of the rectum.

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(Continued from p. 727.)

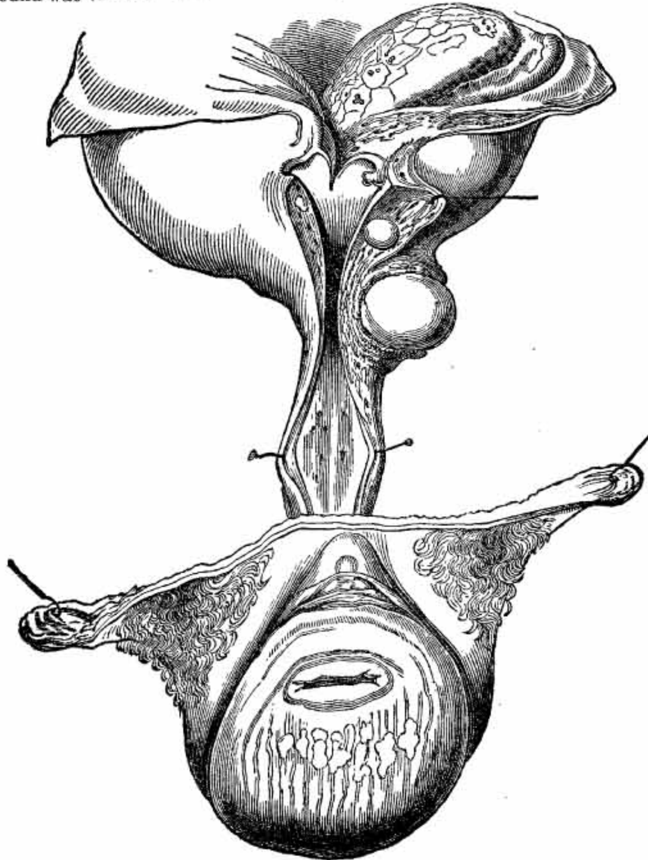
ON PROLAPSUS UTERI, AND SOME AFFECTIONS WHICH ARE FREQUENTLY MISTAKEN FOR IT.

ELONGATION OF THE CERVIX UTERI.

The following interesting case was published by Morgagni:—"An aged woman, at Bologna, had been afflicted with hemiplegia, in consequence of which, for many years, she had been unable to move one side of her body; at length the power of motion in the other side was likewise abolished; a round body also protruded from the vagina. Ultimately she was seized with inflammation of the thorax, and died at this hospital in 1704.

"*Dissection.*—The head exhibited nothing worthy of notice, except an accumulation of serum between the dura and pia mater. The thorax was not examined. I observed that the fundus uteri occupied a lower situation within the pelvis than usual, but its descent was not such as to lead me to suppose the mouth of the uterus so low as it actually was. The labia pudendi was greatly dilated, and a body, three or four digits in length, protruded; this substance was of a cylindrical form, very thick, and its texture resembled that of ligament, except at the bottom, where ulceration had taken place. I perceived that it was the vagina inverted; at the upper and anterior part of this prolapsed body was the orifice of the urethra, and beneath this aperture, on each side, the considerably dilated mouth of a lacuna was visible. In the middle of the lower part there was an orifice, through which the os uteri could be distinguished at no great distance, and I passed a probe through it, without any great difficulty, to the upper part of the cavity of the uterus; surprised at the unusual length of this organ, I cut into the vagina, and within it lay the cervix uteri, extremely lengthened. We could not wonder at this elongation, because the parietes of the cervix itself, as well as those of the fundus, instead of being firm, as they naturally are, were extremely relaxed and flabby, and all the other parts belonging to the uterus, and situated within the pelvis, were in the same condition." (Morgagni, xlv., 2.)

In 1773, M. Levret published, in the fortieth volume of the "Journal de Médecine," three cases of the kind, without noticing the case published so many years before by Morgagni; one of the cases published by M. Levret, was communicated to him by M. Hoin, and the other two came under his own care; after this, as if forgotten, this affection was by some authors altogether unnoticed, and those who did notice it, passed it over so slightly, that in 1832, when I published my case, I thought it was one of very rare occurrence. In a discussion at the Hunterian Society, in the city, after the publication of this case, a physician-accoucheur, and author on the diseases of the uterus, denied the possibility of its occurrence; in reply, I only referred him to the preparation which I gave to Dr. Hodgkin, and from which the accompanying woodcut was taken. At this time I knew of no cases of the kind which were published, except those to which I have referred, by Morgagni, and the three cases by Levret, one of the latter of which I have transcribed. Since this I have met with so many cases in my own practice that I am justified in stating that elongation of the cervix uteri is comparatively of frequent occurrence; in one day I was enabled to show my friend Dr. Marshall Hall three, who was quite satisfied that they were really cases of elongation of the cervix uteri.



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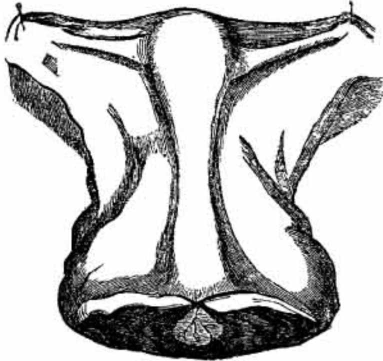
From the similarity of the tumour to that of procidentia uteri, and from the erroneous notion of its being an uncommon affection, it has been often overlooked, and it has been mistaken for prolapsus uteri; but it is easily distinguished from this affection by our being enabled to trace the cord-like elongated neck of the uterus by a finger in the vagina or rectum, and in most instances which have come under my notice, the cervix has been so elongated that I have been unable, either by the rectum or vagina, to touch the body of that organ. The tumour, though greatly resembling that of prolapsus uteri, is not exactly like it; when none of the viscera slip down into the pouch formed by the peritoneum, anteriorly or posteriorly, to the elongated cervix uteri, the tumour is more elongated and much thinner that of prolapsus uteri (Case 1); whilst in the latter case, too, under the same circumstances, the tumour has the form of an inverted cone. When the viscera slip into the pouch in front of, or posterior to, the elongated cervix, the os uteri is not, in either of these cases, found exactly at the lowest part of the tumour; if a portion of the intestines slip into the pouch formed by the peritoneum, posterior to the elongated cervix, the os uteri will be thrown in front, and situated a little higher than the most depending part of the tumour, whilst the woman is standing as the annexed cut, taken from Cruvielhier's



drawing (Case 2, 3) represents; if the bladder be contained in the utero-vesical peritoneal pouch the os uteri will be thrown a little backwards, and a little higher than the lowest part of the tumour, and the circumference of the tumour will be increased, or diminished, in proportion as this viscus contains more or less urine. In this case the bladder is usually *retroflexed*, and we cannot pass the finger into the vagina, in front of the tumour, as in Case 4, on account of the angle formed by the neck of the bladder; the introduction of a catheter will be effected with difficulty unless the tumour be first pushed into the vagina.

If there be still a doubt about the case, and the patient be not pregnant, a bougie may be cautiously passed into the os uteri, and it will be found that, instead of passing two inches and a half, it will pass six or seven inches.

This affection does not usually produce much constitutional disturbance, but it is generally accompanied with pain in the back, and there is a discharge, as in cases of prolapsus uteri.

CASE 1.—Mrs. H—, aged thirty, has had two children, the youngest of which is eighteen months; at the expiration of three weeks after her last labour she discovered something protruding from the vagina, but she experienced no pain at the time; she says that she now feels a dull pain in the back, which goes off after she has been lying down for two or three hours, but the swelling does not recede into the vagina unless she makes pressure upon it with her fingers. The tumour has an elongated form, and protrudes about three inches and a half from the os externum; when she stands the os uteri is at the lowest part, neither inclining anteriorly or posteriorly; I could trace the elongated cervix uteri by passing my finger into the vagina, and I traced it in the same way by the rectum, but in neither way could I reach the body of the uterus; a bougie introduced into the os uteri, passed seven inches before its further introduction was interrupted. Upon examining the tumour externally, from the elongated form of it, and from the os uteri being situated at the *lowest* part of the tumour while the woman was standing, I supposed it a case of elongation of the cervix uteri, uncomplicated either with hernia of the intestines or retroflexion of the bladder, and a careful examination by the vagina and rectum proved the diagnosis to have been correct. The treatment consisted in the application and continued use of the stem-pessary, astringent injections, and the cold hip bath, and regulating the bowels by occasional doses of castor oil. At the end of three weeks the pessary could be retained without the T bandage, and in five weeks more the tumour did not protrude when the pessary was removed for many hours. She is now quite well.

CASE 2.—It is now about fifteen years since I was consulted by an aged person, respecting a tumour which she had observed for the last eighteen months protruding from the vagina; it was large, and when she stood up the os uteri was situated nearly at its lowest part and in front; there was a discharge, of a purulent appearance, and she complained of some pain in the back; the swelling, upon pressing it slightly with the fingers, receded upon lying down, but it again protruded when she rose in the morning. I thought this was a case of prolapsus uteri, and advised a pessary to be worn; but she wore it only a few days, and then discontinued its use, as she said it produced pain and increased the discharge. I heard no more of this patient for a year and a half, when I was sent for to attend her during an illness which proved fatal.

On the post-mortem examination I found the tumour protruding from the vagina, as large as when I examined it during her life-time, and, to my surprise, upon looking into the pelvis, between the rectum and bladder, I discovered the uterus in its normal situation. Upon introducing a bougie into the os uteri, before removing any of the pelvic viscera, I was enabled to pass it onwards more than six inches. Some portion of the small intestines had slipped down into the sac formed by the peritoneum, posterior to the elongated cervix uteri.

CASE 3.—Mrs. N—, married, has had three children, the youngest four years old; about three weeks after her last labour, upon leaving her bed, she experienced pain in the back, and soon after a tumour protruded from the vagina; when standing, the os uteri was situated a little higher, and in front of the tumour there was considerable discharge of mucus from the vagina. The tumour, by a slight pressure with the fingers, when she lay down, returned into the vagina. A stem-pessary was applied, an astringent injection, and a cold hip bath were used, and castor oil was prescribed to be taken occasionally; this plan had been pursued for about three weeks when I last saw her; she has derived great benefit from it.

CASE 4.—Mrs. G——, aged sixty-four, who has had a family, applied to the Dispensary, in consequence of a tumour, of a considerable size, which protrudes from the vagina, and which she says has done for the last four or five years. The os uteri, when she stands, is observed a little higher than the lowest part and at the posterior part of the tumour; it projects three or four inches from the external parts, and its circumference varies in proportion as the bladder contains more or less urine; she has been affected with leucorrhœa for some years, but the discharge is much lessened in quantity since the tumour protruded externally. I cannot pass my finger in front of the tumour, but I can readily do this at its posterior part, and trace the elongated neck, but the body of the uterus is beyond the reach of my finger; I passed the finger into the rectum, along the cord-like cervix uteri, but could not in this way touch the body of the uterus; a bougie, introduced into the uterine orifice, passed to the extent of six or seven inches. There could be no doubt that this was a case of elongation of the cervix uteri, complicated with a retroflection of the bladder. In a few days after I first saw her she was affected with retention of urine, which, I doubt not,

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was produced by the angle formed at the neck of the bladder. Upon an attempt to introduce the catheter, its point met with an obstruction, which was overcome by pushing up the tumour, and thus rendering the angle at the point of flexion less acute. She now evacuates the bladder without the use of the instrument. I introduced a stem-pessary, taking care that the os uteri was, previous to its introduction into the vagina, situated in the concavity of its round plate; an astringent injection was prescribed, and the use of the hip bath, and she was recommended to regulate the bowels by taking castor oil if necessary; this plan produced great comfort at first, but she was obliged to discontinue it for a short time, as she was affected with diarrhœa, after which she again resumed it with benefit.

Case 5.—M. Levret observes,—"Ten years since I was requested to see a lady, residing in Paris, who was said to have a large uterine polypus, in consequence of which I took with me a leaden sound, which I had been in the habit of using where my finger was not large enough to reach the bottom of the vagina, to enable me to form an opinion of the size and attachment of the upper part of the tumour. I found the patient in bed, and, instead of a polypus, there was protruding from the vagina a tumour, of a pyriform shape, somewhat flattened at the sides, and in several places excoriated with a discharge of an offensive odour exuding from the excoriated places. The base of the tumour measured six inches in circumference, and was situated within the vulva; in length the tumour measured six inches at its anterior part, and at its posterior not quite so much; where it was not excoriated it was of a pale flesh colour. When the patient was standing, the os uteri was situated at the lowest part. I introduced the sound, previously oiled, and it passed seven inches before any obstruction was offered to its passage." (Journal de Médecine, vol. xl., page 360.)

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