Account of a Fatal Case of Retroversion at the Fifth Month of Pregnancy. By C. D. MEIGS, M. D., Professor of Midwifery in the Jefferson Medical College. [With a plate.]

THE accompanying lithograph exhibits the appearances as to the posture of the retroverted womb, which it is the object of this communication to describe. The os pubis, with its rami, being removed, a view was obtained of the remainder of the vagina, being its posterior wall, at the top of which is seen the os uteri, slightly dilated. It was very resisting, so that the index finger could not, without much force, be introduced within it. Above the os is seen the thickened and contracted bladder, which has been cut off at the neck. The size of the womb, relatively to the pelvis, is correctly shown, the fundus being adherent to the lower part of the excavation of the pelvis.

The patient, an unmarried woman, was admitted to the Blockley Hospital on the last week of May, 1853. She was twenty-two years of age; had given birth to a child two years ago, and by her own reckoning, was now five months gone again. At the time of her admission to the female ward she complained of abdominal pain, with suppression of urine, distension of the belly, and fever. She laboured under violent tenesmus, and presented the signs of imminent dangerous disease.

Soon after her admission, some bloody urine was drawn off by the catheter, Dr. Steward, the physician-in-chief, having ascertained the existence of retroversion of the womb. The attempts made by that gentleman to relieve the unfortunate woman by repositing the uterus, were wholly unavailing—the fundus being immovably fixed in the inferior part of the pelvis, while the os

uteri could, with some pains-taking, be felt between half an inch and an inch above the top of the pubic symphysis.

Various remedial measures, adopted by Dr. S., did not bring about any material amendment of the patient's condition. In the course of the treatment, a very great quantity of blood was discharged, whether spontaneously or by the catheter, from the bladder of urine: but notwithstanding these cares, together with a sedulous attention to the regulation of the alvine evacuations, the woman's distress became constantly greater. On the 9th day of June, Dr. S. did me the favour to invite me to a consultation with him on the case; and, upon a very carefully conducted research, it was agreed: 1. That the bladder was still greatly distended, though Dr. S. had allowed a flexible French catheter to remain within the bladder for several hours. Yet when this catheter was withdrawn, the bladder was still greatly distended, and lying upon and in front of that portion of the womb that had risen above the plane of the superior strait of the pelvis. Its outline could be distinctly traced through the abdominal integuments. The resistance of it showed that the contents were concrete, and not fluid. A metallic catheter introduced into the cyst brought away putrid grumes of long-coagulated blood; and, upon injecting tepid water through the catheter, the liquor returned charged with the most putrid colluvies mixed with broken clots, evidently of long standing. 2. The os uteri could with difficulty be reached by the index finger carried above the top of the pubis, and the posterior wall of the womb inclined downwards and backwards into the bottom of the recto-vaginal *cul-de-sac* of Douglass. A protracted effort, which I made, to elevate the fundus, and bring the cervix down, proved fruitless, though, in making it, I caused the patient to place her sternum on the bed, and raise the hips by bringing the knees vertically beneath the pelvis; which is the best possible position to favour such an operation. 3. The failure of all attempts to reposit, whether by the hand, by the use of the catheter left *in situ* for many hours (a method heretofore much recommended), or by Hervez de Chegoin's elastic caoutchouc bags, gave reason to believe that the retroversion was incurable in consequence of adhesion of the fundus with the back part of the pelvis. But, as this diagnostic could only be deemed presumptive, and not demonstrative, it was concluded that the cares should be continued, with a view to wash out the putrid grumes from the bladder; and it was, perhaps, reasonable to hope that, if the bladder could be wholly relieved of its solid distending contents, it might become possible to push up the fundus, and show that the apprehensions as to adhesion were groundless.

On the 18th of June, the woman died in the night, having been quite relieved of the putrid coagula, and having also partially recovered power to pass the urine without the catheter.

I was again obliged to Dr. Steward for his great kindness in inviting me to witness the *post-mortem* examination, which took place at the Blockley Hospital, at 4½ P. M., of Sunday, June 19, 1853. There were present Dr.

Steward, Physician-in-chief to the Hospital, assisted by Drs. Taylor, Coleman, Taggart, Budd, Marseilles, and Barksdale, of the house, and the undersigned.

The contemplation of such a case affords a most useful practical lesson; it is, that all women who labour under retroversion of the uterus, are, in addition to the pain and other inconvenience arising from the accident, liable to no inconsiderable risk of adhesion of the fundus in the bottom of the pelvis. Such adhesions are not very uncommon; and, as they are inaccessible to the surgeon, must be regarded as incurable.

A woman with adherent retroversion is liable to conceive; and, in that event, can only escape from death by abortion; since the progressive development of the ovum must, as early as the fifth or sixth month, pack the cavity of the pelvis so completely, as fatally to obstruct the offices of the rectum, the ureters, and the bladder.

In all such cases the sole resource is in a forced abortion; and the practitioner should feel warranted, in formal consultation only, to proceed to the performance of the proper operation.

In a case where it might be practicable, he would rupture the ovum by means of a womb-sound introduced within the canal of the cervix. It might, however, be impossible to do so on account of the great elevation of the os above the symphysis. It could not have been done in Dr. Hunter's case, described in his famous tables of the gravid womb. I do not know that it would have been practicable in this case. A sure method of compelling the womb to contract consists in puncturing the organ with an exploratory trocar, by which the amniotic liquor could be withdrawn perhaps with little damage to the womb itself. Labour would sooner or later ensue upon the discharge of the waters. Where the ovum cannot be reached through the os and neck, the trocar would be allowable.

Dr. Steward could not feel justified to perform such an operation, in this case, complicated as it was with so violent an attack of cystitis. I do not hold that the surgeon is bound to compromise the glory of his art in a mere faint hope that good might follow an act of questionable propriety.

The remains exhibited the appearances so common to those who die rapidly with violent disease, and the dissection showed that the immediate agent in the destruction was an intense cystitis, ending in ramolescence and perforation of the bladder, with consequent escape of urine into the peritoneal cavity.

The *embon-point* was considerable.

The abdomen was much distended with gas, and sonorous on percussion.

A crucial incision exposed the contents of the abdomen. The colon was enormously distended, the small intestines considerably so. The peritoneal sac contained twelve to eighteen ounces of serum. No inflammatory exudation was observed causing the convolutions to cohere.

The mesentery and mesocolon being cut away at the root, the alimentary

canal was removed, leaving a clear space to pursue the rest of the dissections.

Attempts to reposit the uterus were now renewed, by thrusting the hand down betwixt the uterus and the curve of the sacrum, but they were protracted and repeated in vain. The fundus could not be pulled up from its place in the recto-vaginal *cul-de-sac*.

The gentlemen hereupon cut away the pubis with a saw, which passed in front of the acetabula, and through the rami of the ischial bones. Upon removing the bone, the os uteri was exposed. A ruler being laid across the hypogastrium, on a level with the anterior superior spinous processes of the ossa ilia, showed us that the os was within an inch of a line drawn from one spinous process to the other, which shows how completely the organ was turned topsy-turvy.

After the ossa pubis were taken away, with difficulty I passed the index finger of the left hand into the os, and the whole of the right hand down behind the mass of the womb in front of the sacrum. In this way I employed a great deal of force in a vain attempt to reposit the organ. But no effort did or could succeed until a quantity of strong adhesion, that had bound the fundus to the lower part of the sacrum, was destroyed with a bistoury; whereupon, the slightest effort sufficed to reposit the os uteri, which descended into its place.

The womb and vagina, with the bladder and rectum, being next carefully taken out of the pelvis, it was seen that the bladder was empty; an incision being made, its coats were seen to be greatly thickened. The whole mucous surface was covered with exudation-membrane, and the tissue was so far gone in inflammatory ramolescence, as to tear like wet paper. A perforation was observed which must have given issue to the urine; which, falling into the peritoneal cavity, developed the extensive peritonitis, the product of which was exhibited in the serous deposit already mentioned.

The next step was to an examination of the womb. An incision being made, with care, to avoid opening the membranes, it was carried up to the edge of the placenta, which was seen attached at the fundus.

As I have on various occasions published my views concerning the mode of connection betwixt the placenta and the womb, I was desirous that all the gentlemen should avail themselves of so good an opportunity to judge for themselves as to the facts in this case. Wherefore, exposing the object in a clear light, they were earnestly exhorted to observe critically the appearances to be presented during the process of separating the placenta from the womb.

The ovum was still unruptured.

Taking hold of the cut edge of the uterus with two dissecting forceps, and gradually raising the edge, or margin; from the basin in which it was held, the unbroken ovum very slowly rolled out from the opened organ, thus effecting the separation by force of gravitation. Each one of the company carefully scrutinizing the appearances, endeavoured to discover any signs of broken tractus

of bloodvessels as the placental surface slowly drew itself away from the uterine surface, and it was agreed by all of the gentlemen that not a bloodvessel was either broken or drawn out during the entire act of separation. The appearances were so similar to those witnessed during the avulsion of a placentule from a cotyledon in the ruminants, as to convince me that the same mechanical principle is employed by nature in both cases, as it certainly is in the solidungula, in the pachydermata, the rodents, and the cetacea.

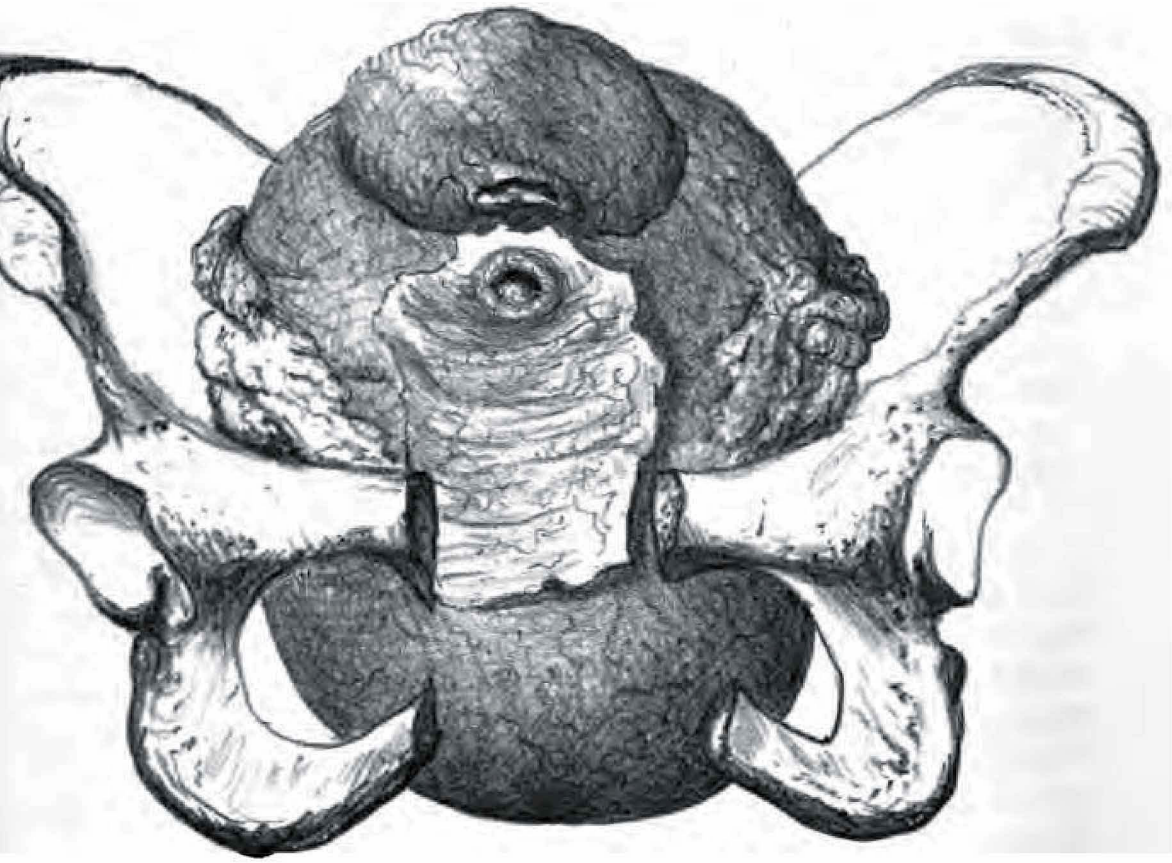
I cannot refrain from expressing the satisfaction with which I observed this confirmation of the doctrine I have always felt it my duty to maintain, as well in my public lectures as in my printed works.

The embryon was well developed, at about five months and a half of utero-gestation. The liquor amnii was pure and transparent, and the substance of the uterus perfectly normal. The fundus still shows the remainder of the adhesions, which, by preventing the reposition of the womb, gave rise to the disorders from which the unhappy patient perished.

Both the kidneys were highly engorged. The pelvis and ureter of the right side were greatly dilated. It is probable the hæmaturia came from this kidney, possibly from both the kidneys.

My frequent experience in treating disorders of women, convinces me that cases of retroversion of the womb are much more frequent than is supposed. And this is the more surprising since no diagnostication can be more easily and certainly made.

The cases have undeniably proved very difficult to cure; and there may, perhaps, be some individuals who resist every method of treatment, in consequence of a permanent relaxation of the ligamenta rotunda, and ligamenta utero-sacralia. I shall, however, find it very hard to admit that a woman afflicted with retroversion merely, and wholly free from adhesion of the fundus, would not get quite well, provided a discreet use should be made of the annular pessary, described by Dr. Charles Evans, in a communication to the Philadelphia College of Physicians, and published in the *Transactions* of that College.



D.r MEIGS' CASE OF RETROVERSION