

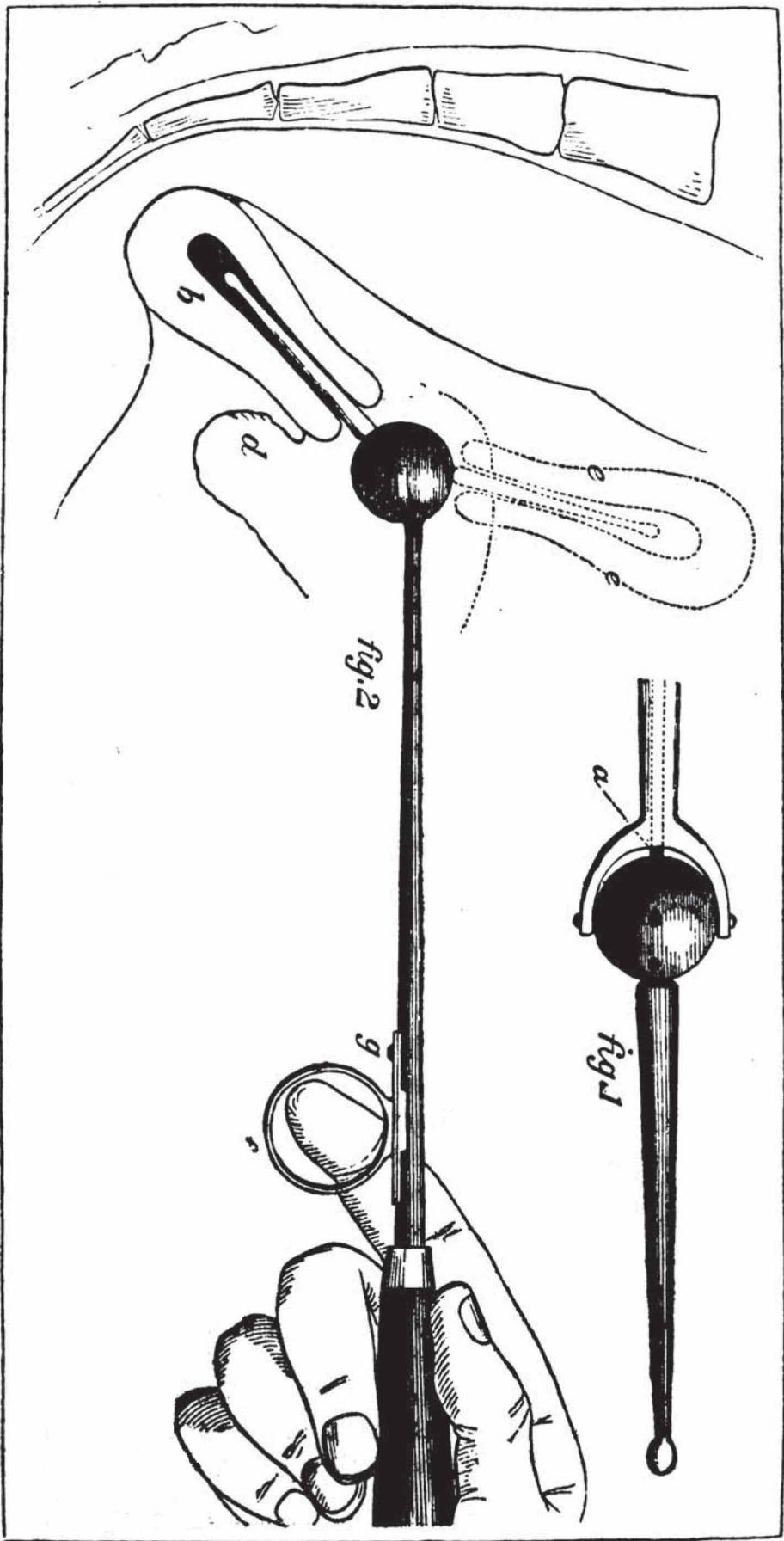
ART. XI.—*A New Uterine Elevator.* By J. MARION SIMS, M. D., Surgeon to the Woman's Hospital, New York.

OF all malpositions of the uterus, retroversion is the most common. Dr. Meigs, who is certainly the highest authority amongst us in obstetric medicine, says it comprises 75 per cent. of all cases that fall under his observation. Whatever, then, facilitates its removal is of importance to the profession. As a means of diagnosis Simpson's sound is perfect, and in many cases indispensable; but as a remedial agent it is susceptible of improvement. When passed downwards and backwards into a retroverted uterus, and then rotated half round on its own axis, thus suddenly elevating the organ, it often lacerates the lining membrane, as shown by severe pain and hemorrhage. Besides, if the surgeon has unfortunately given it too large a curve, the whole weight of the uterus will be sustained upon the point of the instrument as it strikes against the fundus, which, we are told, has produced perforation, with fatal consequences. This accident, however, cannot happen if the curvature be made short, and not more than $2\frac{1}{3}$ inches from the end of the instrument; for then the weight of the uterus will be sustained principally at the point of contact between the anterior lip and the sound at its curvature. But while the short curvature obviates the danger of perforation, it does nothing for the prevention of pain, and of violence to the uterine cavity.

I have long thought that Simpson's sound could be improved by making a joint or hinge in it near enough the end to prevent its striking against the fundus, and yet far enough to allow its fully entering the cavity, which, making the os tincæ the centre of motion, would enable us to roll the body in a right line directly upwards, instead of throwing it round by a lateral sweep, as when the instrument is rotated on its own axis. This idea is practically illustrated in the Uterine Elevator (see Fig. 2), which the artist has so well represented that further description is almost useless. It is about 13 inches long, and consists of a handle (3 inches), a shaft (7 inches), and a uterine stem ($2\frac{1}{3}$ inches), inserted into a ball which revolves at the end of the shaft, its axis being at right angles with that of the instrument. The ball is of ivory, about $\frac{3}{8}$ ths of an inch in diameter, and has a belt of perforations $\frac{3}{8}$ ths of an inch apart, extending around in a line with the stem. The shaft is a hollow cylinder containing a rod which is retracted at will by the slide *g*, Fig. 2, or pushed forwards by a spiral spring so that its point may lodge in any one of the perforations in the ball, whereby the stem may be held firmly at any desirable angle with the shaft.

Fig. 1 represents the upper part of the shaft with its rod *a*, the ball with its perforations, and the uterine stem, all nearly of the exact size and proportions. Fig. 2 represents the practical application of the instrument.

The sense of touch is sufficient to show the position of the uterus, and by



Simpson's sound we measure to the fraction of an inch its depth and degree of flexure. Then, and not till then, are we ready for the Uterine Elevator, taking care to adjust the stem best adapted to the case. The stem is set at the required angle with the shaft, and thus passed into the retroverted uterus *b*, with the ball close up to the os tinæ; then, by pulling back the slide *g*, the rod *a* is drawn out of the perforation in the ball, when it is free to revolve in the direction opposite to that of the motor power. Thus by depressing the handle and pushing the ball up towards the promontory of the sacrum, the uterus becomes further retroverted, but by pushing it gently and firmly downwards and backwards into the vaginal cul de sac *d*, the inevitable result is to revolve the stem with the uterus *b*, directly upwards, as shown by the dotted lines *ee*. The uterus may be arrested at any point of this evolution, merely by letting go the slide that holds the rod; or, the movement may be continued till it is completely anteverted, while the weight of the organ will be sustained mainly by the cervix resting on the ball. There are three stems which screw into the ball, one 2 inches, one $2\frac{1}{3}$, and the other 3 inches long, but the medium size is the one ordinarily used. Whenever the long or the short one may be needed, the previous use of Simpson's sound will indicate it. The instrument may be made of silver, of copper silvered, or of German silver. I prefer the first two, because the stem often requires a little flexure to adapt it to acute uterine curvatures, particularly where there is much cartilaginous degeneration of tissue. German silver is not soft enough for this purpose.¹

After the malposition is rectified, it will, of course, require some mechanical contrivance to keep it so: whether Meigs' ring, or Hodge's instrument, or some of its various modifications, or Simpson's intra-uterine stem, will depend upon the peculiarities of the case, and the tact and judgment of the operator.