THE QUESTION OF PELVIC SUPPORT.*

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Truth is stranger than fiction; and, as in the scarcity of gold and diamonds lies the essential element of their value, so the scarcity of truth magnifies its value when secured. The language of Holy Writ is still to us an inspiration, "Seek and ye shall find." All truly valuable progress is in direction from the complex to the simple, from the useless to the useful, from the false to the true.

In the evening twilight of the year and century, may we not profitably take an invoice to determine what we have in stock worth carrying forward to coming years or coming centuries; and, if, perchance, we shall see our idol falling, let us have consolation in the thought that "we have written as those who love humanity." Many of us can count by the score our patients whose pelves are minus ovaries and tubes; a few of us can count by the hundreds our patients whose pelvic organs have been reduced in number until nothing but bladder, ureters and rectum remain. May we not well inquire what means and methods have best borne the test of time (which proves all things), and left the pelvic viscera in so nearly normal position as to give in greatest measure pelvic strength and pelvic support to the remaining organs?

When about nine years ago I had occasion to re-open an abdomen ten months after I had removed a large fibroid tumor (in which case I had used a serre-nœud and adjusted the pedicle in the lower angle of the wound),I found that what was considerable of a pedicle at the first operation had been reduced to a string not larger than a pencil, composed of peritonæum enveloping a small amount of connective tissue, and even this had been broken by a sudden strain which the woman received while driving a buggy over a railroad crossing. While this had given way, the vagina had been retained at full length for such a time that the broad ligments maintained a good support to the vagina, and recent examinations disclosed the fact that the patient, though a hard-working farmer's wife, now sixty years of age, has neither rectocele nor cystocele. In my earlier experience with panhysterectomy, the case which I just reported was continually in mind, and I made every effort to retain the vagina at full length by securing its union with broad ligaments. Notwithstanding this, as my patients

* Read by invitation before the Philadelphia Obstetrical Society, December 2, 1897.

have grown older, I find shortened vagina, and in many cases resulting cystocele, vesical tenesmus, or rectocele with lack of expulsive power in the lower portion of the rectum.

In many cases where I have first secured the uterine arteries and made a supra-vaginal amputation of the cervix, I have made effort to stitch cervix together and give it as much attachment to the broad ligaments as possible, to avoid shortening the vagina and resulting cystocele and rectocele. Surgeons who have visited my operating-room and lookers-on, when operating before medical societies, have asked, "Why use suture at all in the cervix," saying, "if let alone it would retract," as the turtle retracts its head into its shell. I have but one answer to such quesions, and that is, this retraction of the cervix is caused by a contracting and shortened vagina, and I desire to have the patient's bladder and rectum held up as nearly in normal position as possible. It took the first half of the century to put ovariotomy on an everlasting foundation. The removal of fibroid tumors has in twenty years, not only become a recognized operation, but hysterectomy has to-day, if anything, a lower mortality than ovariotomy. Let us reason together: The brave woman who has to give up her womb surely is entitled to the method which leaves her pelvis the strongest and least impairs the function of remaining viscera.

With these statements in mind and some experience to sustain our views, it might seem that ventral-fixation of the pedicle and a return to the serre-nœud of elastic ligature, would give better pelvic support. In a large per cent. of cases I believe this to be true, and believe that those who have opened the abdomen at a later period after fixation of the pedicle in the abdominal wound, have found nothing but a string remaining and in some instances that string broken. There are other advantages which I might digress enough to mention; mainly, that the two wounds, one pelvic, the other abdominal, are united in one; and if the serre-nœud is never tightened after the patient leaves the operating-table, there is no more danger of infection from the stump than from an abdominal suture, which is not twisted and tightened, and irritated by such daily twisting and tightening.

Twelve years ago I began doing vaginal hysterectomy for cancer, pelvic inflammation, and for cases of complete procidentia. In my first five efforts I used the dorsal position and either clamped with ordinary large hæmastats or ligated with silk, paying little or no attention to the attachment of the vagina to the broad ligaments for the purpose of preventing vaginal shortening and resulting cystocele In examining one of these patients from whom I had removed the uterus

for complete prolapse, I found decided shortening of the vagina with large rectocele and cystocele to the extent that the patient never completely emptied the bladder, suffering so much from vesical tenesmus that she expressed herself as having been more comfortable when her womb was "out in the world." Emmet's operation on the perinæum and Stoltz's operation for the cystocele have rendered her comparatively comfortable. With these object lessons in mind, in cases of complete procidentia, instead of vaginal hysterectomy, I have made a modification of the operation devised by Mackenrodt, making a longitudinal incision in the anterior vaginal wall from a point one inch back of the urethra down to the uterine cervix; then going through the utero-vesical space into the peritonæal cavity, bringing the uterus forward to a position of complete anti-version and stitching it with silver wire, following up with the Emmet operation, which deals with the perinæum from the vaginal side. The results thus far have been very satisfactory, and, as I believe, if we limit its use to cases past the menopause, make a field for the Mackenrodt operation, which seems otherwise to have been doomed because of the bad results when pregnancy occurred.

Since 1886, whether using ligature or clamp in vaginal hysterectomy, I have taken pains to narrow and round the broad ligaments by a constricting ligature, not only dragging them forcibly down into the vaginal wound, but dragging the vagina upward as much as possible by suture as indicated on the photograph. I have, in most cases, found, by examination a year later, vagina drawn upward with a depression on each side where broad ligament has retracted. Where I have been compelled to leave the pelvic wound open packed with gauze a year or so later cystocele and rectocele have been found.

In vaginal hysterectomy I am careful not to drag the uterus down into my light, but crowd it off to one side while dealing with the broad ligament; always using the Sim's position (first having the rectum dilated so as to give us the largest amount of space). Thus, by this position, all the pelvic organs are on a traction upward, while the operation is being made, the whole procedure being diametrically opposite to the French method, which turns the vagina nearly wrong side out, shortens it one-third its length, then holds up the intestines with gauze instead of closing the wound, thus paving the way for cystocele and rectocele.*

* Jacobs, after returning to Paris, ties off his forceps with silk bought in Philadelphia, and closes his wound in some cases.—Personal communication, Dr. Palmer Dudley, N. Y.

In not less than one-half dozen cases of retroversion with more or less accompanying prolapse, I have sought to overcome the disorder by the so-called ventral-fixation using three silk sutures passed through the posterior wall of the uterus and including at times the sheath of recti muscle, the subserous areolar tissue and peritonæum. Examining these patients two or three years later, I find the uterus prolapsed and retroverted as badly as ever, and in one case where it became necessary to open the abdomen I found little evidence of any suspending ligament remaining. In very many operations in the peritoneal cavity for intestinal obstruction due to strangulating bands, we find that these bands are continually being elongated by the floating about of the ever-moving intestines. In each act of *inspiration* and *expiration* anything attached to the abdominal wall will be alternately stretched and relaxed so that ultimately it will become elongated to a mere strand and amount to nothing by way of supporting uterus and other pelvic organs. In confirmation of this statement report the following case.

Some two years ago I gave the method suggested by Thomas Keith a fair trial. I lifted the retroverted and prolapsed uterus by the ovary and tube, and as much of the broad ligament as I could drag up into the abdominal wound, fastening it there by suture and clamp, removing the ovary and outer end of the tube. A year later the patient returned with uterus as much prolapsed and retroverted as ever. I reopened the abdomen, found the suspensory ligament, which I had made out of the mesovarium and fallopian tube very much relaxed, permitting the greatest freedom of descent and retroversion of the uterus. It may be said that the uterus held up for a time by ventral fixation, may relieve the patient of pelvic tenesmus. I would only answer that it can be claimed that the Hodge-Smith pessary has done all this, with more benefit and less danger to the patient and *is in evidence* that a *good* and beneficent means of relieving suffering originated in Philadelphia.

In many cases where I have removed ovaries and tubes and found accompanying retroversion, I have taken loop in the round ligament, thus shortening it, and for a time at least maintaining the proper axis of the uterus to that of the vagina. In this way I believe I have avoided the pain which continues in some cases for months, where the uterus sags backward, producing traction upon the pedicle.

Not wishing to digress from the subject of pelvic strength in women who have had to give up pelvic organs, I would say that the whole uterus contributes in no small degree to pelvic strength, even in

cases where the adnexæ have been removed, and I cannot allow to go unchallenged the statement that the uterus is no longer of any use after ovaries and tubes have been removed. In not less than twenty per cent. of my cases menstruation has continued after removal of the ovaries and tubes. I believe that Mr. Tait concedes that it has continued in fifteen per cent. of his cases; therefore, in a considerable per cent. of cases the senile changes which occur at the menopause, when precipitated by an operation, are avoided; menstruation in these cases is evidence of pelvic life, and pelvic life means pelvic strength and pelvic strength often contributes to a healthy body and a healthy state of mind. Oh, the pitiful mental and physical wrecks, wafted to the gynæcological shores from the great ocean of life—wrecks which have gone down beneath the surging waves of unsubdued passion and unrequited love! Shall love be more or less requited when the wife has no passion to subdue? What wrecks are being wafted from the ocean of surgical aggression to the tender mercies of the family physician; let him answer for our instruction.

I have removed spleens, kidneys, gall-bladders, wombs, ovaries and fallopian tubes, always feeling after such effort that not quite a whole being is left, and am of the opinion that it should be a surgical law to remove no organ (except the vermiform appendix), unless the same be incurably diseased, and with diseased ovaries and tubes removed, the uterus in most cases by proper treatment can be saved to occupy its position as the keystone in the pelvic arch, maintaining its proper axis to that of the vagina, lifting up rather than weighting down.

When a woman places her confidence in the operator who has said to her that, "she owes it to her family to submit to a formidable operation in order that she may be restored to health and happiness," she often displays a heroism such as only a woman believing that she is acting in the interests of her home is capable of showing. The history of the world gives few examples of self-sacrifice and heroism such as the surgeon often finds in his womanly patients:

> So near to grandeur is their dust,
> So nigh to God is man,
> When duty whispers, low, "Thou must";
> Their hearts respond, "I can."

Much is due these self-sacrificing beings. By all the hallowed memories which cling to the words mother, wife, sister or daughter, let us resolve and ask high heaven to record the vow that we will submit no woman to an unnecessary operation nor avoidable mutilation, and

that while during no operation will we remove a single organ which she might be permitted to retain:

> All are but parts of one stupendous whole,
> Whose body nature is, and God's the soul.

Some of these poor suffering creatures come to us in their desperation, demanding relief by surgery and it may, and often does become our solemn duty to reflect, "If this were my own wife, sister or daughter, would we do this operation or feed the nerve cells with a view of increasing her tolerance of pain?" The uterus, something like the parrot, will do the talking for every organ of the body and mimic every disease in the encyclopædia of pathology. The pelvic organs are as dials upon which are expressed the ills of the entire body in many of the neuroses. How few of us can positively differentiate between profound neurasthenia expressing itself in the pelvis and diseased pelvic organs causing and maintaining profound neurasthenia?

I have written this paper not for the purpose of inviting approval from this learned body nor in the spirit of the iconoclast but rather with the view of eliciting discussion; discussion, in which I may be the attentive pupil, anxious and willing to be instructed. In short, it was not written to please others but to please myself.

We have sent forth a good deal of Seidlitz powder literature; literature which, read by the surgical aspirant, is as fuel to the fires of surgical aggression. While I have the utmost admiration for the bold surgeon, and think the very acme of the world's heroism was attained when Mrs. Crawford clasped hands with McDowell, and made her leap for life, my admiration for the bold surgeon warms into fervent flame of love when I learn that his boldness is always tempered by wisdom, and his conscience holds him firmly to the golden rule: "Whatsoever ye would that men should do unto you, do ye even so unto them."

We must never allow the glare of surgical triumph to swerve us from the line of duty to a fellow-being. In the beginning of our special work, many operations were new and untried; many things were published to the world which had not been tested in the crucible of time and truth.

> Had we but sought for truth, with all the zeal we sought for fame,
> We had been wiser in our day, and left a loftier name.