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CŒLIOTOMY IN THE TREATMENT OF THE INCARCERATED PREGNANT UTERUS WHEN IRREDUCIBLE.

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Pregnancy may occur in a retrodisplaced uterus or the organ may become displaced in the early months of pregnancy. The physiological softening of the lower segment leads, in such cases, to early and exaggerated retroflexion of the gravid womb. By rapid growth the uterus fills the posterior half of the pelvic basin, and is imprisoned by the projecting promontory of the sacrum. Continued increase of size is limited by the capacity of the true brim. Either spontaneous replacement occurs, or abortion follows, or severe and dangerous pressure-symptoms develop.

Properly applied treatment under anæsthesia will, as a rule, correct the displacement even when firmly incarcerated. In the small number of cases which resist these efforts at restoration, the production of abortion, or, more recently, vaginal hysterectomy, are the only methods of treatment recommended. Owing to the displacement of the cervix forward, and the acute angle formed at the internal os, more than usual difficulty and danger attend the artificial emptying of the uterus. Deficient drainage of the uterine cavity adds to the risk of sepsis. In the hope of saving the pregnant woman's life, vaginal hysterectomy has been employed as a last resort.

As an alternative for abortion or hysterectomy, a new method is here advocated.

The gravid uterus, displaced and irreducible by the means

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that have been at our command when manipulating from below, is successfully replaced by operating from above. The abdomen is opened in the usual way, the fundus and the body of the uterus grasped by the fingers, and by manipulation directly applied in this way the displaced organ is lifted from its bed and brought into normal position.

This method was successfully carried out in a case operated upon, April 24, 1896. The patient was a colored woman aged twenty-three years, a multipara, who entered the hospital complaining of severe bearing-down pains and bladder symptoms. She passed her urine every half hour with much pain and tenesmus. Gestation was advanced between three and four months, and examination revealed a retrodisplaced uterus. All efforts to correct the position having failed, the abdomen was opened, the fundus released and brought forward and fastened by two buried silk sutures to the abdominal wall. The patient made an uneventful recovery, and left the hospital on June 10th. She passed through a normal pregnancy, and returned at its termination to be delivered after a natural labor. The puerperium was free from complications, and when finally dismissed from the institution her uterus was in normal position.

The application of cœliotomy to the treatment of this complication was original so far as the writer is concerned, and he was not aware at the time of its having been performed before.

Dr. Matthew D. Mann, of Buffalo, reported two cases to the American Gynecological Society at its meeting in Boston, May, 1898. In his first case he was uncertain of the diagnosis until after the abdomen was opened. This was in November, 1895. His second operation was at the Buffalo General Hospital on July 22, 1897. The diagnosis in that case was retroflexion of the pregnant uterus, with incarceration. After cutting through the abdominal wall the peritoneum was found drawn up by the distended bladder. This was tapped, and a large quantity of urine drawn off before the peritoneum was opened and the uterus replaced. Both

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cases terminated successfully. Dr. Mann says a careful search through the literature of the past five years failed to reveal but one similar case, which was reported by Dr. Murdoch Cameron, of Glasgow, in the *British Medical Journal*, 1896, vol. xi. p. 1277.

The case was exactly similar to Dr. Mann's second case, and was operated upon in the same manner. Doubtless many times the abdomen has been opened in unsuspected cases of pregnancy to relieve retrodisplacements with or without other pathological conditions. In Dr. Mann's first case the diagnosis was in doubt between a retroflexion of the gravid uterus or a cyst behind the uterus. Dr. H. Lapthorn Smith, of Montreal, says[1] he operated upon a woman who was supposed to have an ovarian cyst, but found a retrodisplaced pregnant uterus. He brought it forward and stitched it to the abdominal wall. The woman passed through her pregnancy, and was confined at term. Dr. Malcolm McLean reported in the same discussion a case he had met with some three years before. The uterus was incarcerated in the true pelvis, and there was a tumor extending into the abdomen, which proved to be a hernia of one portion of the uterus. As soon as the organ was released it assumed its usual shape, the woman went to full term, and was delivered normally.

Dr. J. C. Da Costa reported to the section on gynecology, College of Physicians of Philadelphia, May 20, 1897, a case of retroflexed and adherent pregnant uterus with a cyst of the right ovary. After removing the cyst the adhesions were broken up, and the uterus resumed its proper position. Recovery followed, and Dr. Da Costa wrote me that she was delivered at full term of a healthy girl weighing nine and a half pounds.

Commenting on this case Dr. Da Costa says: "This operation seems to justify the ground that I have taken for some years past, that the proper way to treat a retroflexed pregnant uterus which is bound down by adhesions is to do a cœliotomy to free it."

[1] American Journal of Obstetrics, 1898, p. 279.

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The object of this paper is to recommend cœliotomy and reposition of the displaced gravid womb, not only when adherent, but when incarcerated and non-adherent.

A question open for discussion is whether or not, after replacing the uterus, ventral suspension should be performed. Dr. Mann, in closing the debate excited by his paper, said: "It seemed to him that any one who had once pulled out one of those uteri from beneath the sacral promontory, and had experienced the difficulty in doing this, would hardly think it necessary to perform ventral fixation." This is true so far as any danger of immediate recurrence is concerned, but we know that these displacements invariably recur after childbirth. The woman recovers with a retrodisplaced uterus, and if conception should again take place she is liable to a recurrence of the complication. When a woman under these conditions submits to cœliotomy she is entitled to more permanent benefit than merely replacing the gravid uterus. If ventral suspension can be performed at the same time without increased risks, permanent and not temporary results are attainable.

The increased risks are the dangers of interrupting the pregnancy and producing an unfavorable influence over the confinement. Neither of these results followed the two cases reported—that of Dr. Lapthorn Smith and of the writer. Unless future work shall prove that these dangers outweigh the advantages, ventral suspension properly performed should be added to the cœliotomy and replacement of the gravid uterus.

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