THE SURGICAL TREATMENT OF IRREDUCIBLE RETROFLEXION OF THE GRAVID UTERUS.

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The alternatives which have been given us, up to the present time, in cases of retroversion of the gravid uterus, with incarceration, are either to replace the uterus, or, that being impossible, to empty it; the argument being that if we leave the uterus displaced, the death of the mother and child will result; whereas, if we empty the uterus, the mother may be saved, although the child be lost. This teaching, in the light of recent experiences in abdominal surgery, should be changed; and, if it be found impossible by the most improved methods, including the use of anæsthesia, to replace the uterus, the abdomen should then be opened and the fundus pulled up by the hand introduced behind it. If the uterus be so large as completely to fill the pelvis, efforts at replacement through the vagina will fail, not because the uterus is too large to be forced through the pelvic brim, but because, filling completely the pelvic cavity, when it is pushed up nothing can enter from above to take its place; so that its progress is limited, and the moment pressure is withdrawn from below atmospheric pressure forces the uterus down again into its old false position. This occurs even in the knee-chest position. The truth of this statement will be readily appreciated by anybody who has operated on one of these cases. Even if the uterus be soft and yielding, it requires considerable manipulation to get it up, and it can only be done by letting the air in behind it.

It must not be forgotten that pregnancy may exist when there are adhesions, and that these may be an insuperable bar to reposition until they are broken by the hand on the inside, thus giving another indication for operation.

The following cases will illustrate the method.

In November, 1895, Mrs. A., aged thirty-five years, married and the mother of several children, the last six years before, presented herself at my private hospital for treatment. Since the birth of the last child she had had a number of miscarriages. She stated that the menses had been absent for four months, and during that entire period she had been feeling very badly. There was great pain in the pelvis, with inability to empty the rectum and bladder; she could not walk or stand without pain. Examination showed the pelvis filled with a soft, apparently thin-walled, fluctuating cyst behind the cervix. It was not very tender, but was quite firmly fixed. The cervix was crowded well forward to the symphysis; the position of the body of the uterus was uncertain, but I thought I could feel it above the symphysis. The patient had often felt what she called "the tumor" in the vagina, and said she was sure it had been there for a long time, for how long she did not know.

The diagnosis was uncertain. Either it was a retroflexion of the gravid uterus or a cyst behind the uterus and filling the pelvis. I was unable to determine positively which. It was utterly impossible to push the mass out of the pelvis, although various methods were tried, including the knee-chest position, pulling down of the cervix with the vulsellum, and the making of firm pressure through the posterior vaginal pouch. The matter having been explained to the patient, and the advisability of opening the abdomen being shown, she consented to the operation. After emptying the bladder and making an incision into the abdominal cavity, I found that I had to deal with a retroflexed gravid uterus. I introduced my hand behind it, and with considerable difficulty succeeded in getting the fundus up out of the pelvis. As I have said before, atmospheric pressure was the principal hinderance. I then closed the abdomen. The patient made a prompt and uninterrupted recovery, and left the hospital perfectly well. I have not heard further from the case.

The second case was similar, but presented some different points in the operation.

The patient was thirty-nine years of age, and had had several children. The diagnosis was retroflexion of the pregnant uterus with incarceration. All efforts at replacement failed, and the patient continuously grew worse. The bladder was greatly distended and was not emptied by the passage of a catheter.

On July 22, 1897, at the Buffalo General Hospital, I opened the abdomen in the usual place. After cutting through the abdominal walls I found that I was below the peritoneal cavity, the peritoneum having been greatly drawn up by the distended bladder. I tapped the bladder at this point and drew off a very large quantity of urine, and then closed the opening with a few catgut stitches. After opening the peritoneum the hand was introduced, and with considerable difficulty, as in the other case, the uterus was replaced. A catheter was retained in the bladder for two days. The patient left the hospital August 11th in perfect health, her temperature never having been above 99°. She writes me that she went through her pregnancy and labor without any unusual symptoms.

A careful search through the literature of the last five years fails to show any similar case, except one reported by Dr. Murdoch Cameron, of Glasgow.[1] His case was almost a repetition of my second case, and was treated in exactly the same way, including the tapping of the bladder under the peritoneum. His patient made a good and prompt recovery. His case was done about a month later than my first case, but was not published until the year following, and I did not see his article until I came to write this paper. We therefore arrived independently at the same concluion regarding the treatment of these cases, which may be taken as a indication of the correctness of our opinion.

Experience would therefore certainly indicate that where we have an incarcerated retroflexed gravid uterus the abdomen should be opened as a last resort, rather than that the uterus should be emptied.

[1] British Medical Journal, 1896, vol. ii. p. 1277.

DISCUSSION.

THE PRESIDENT.—I would suggest that the members confine their remarks to the operative treatment of these cases.

DR. HENRY D. FRY, of Washington.—In the fall of 1895 I had a case in which there existed a condition similar to that in the case reported by the author. The patient, who entered the hospital when she was three and a half months pregnant, suffered from the usual symptoms of incarceration—*i. e.*, pressure and bladder symptoms. A physical examination, together with the history of early pregnancy, made the diagnosis very clear. This condition of incarceration of the pregnant uterus is common, but in most cases it is reducible. Under anæsthesia an attempt at reduction was made, for I have often done this. In this case, however, I failed, and the abdomen was opened, which was justifiable under the circumstances, as other alternatives would have proved more serious to the mother, and would necessarily have sacrificed the child. After making the abdominal incision the uterus was lifted up into position, and, fearing that it might again fall back, I did a ventrofixation. The patient made a good recovery from the operation, and was delivered at full term without any difficulty, after having been closely watched during the remaining months of gestation. The uterus was in good position when the patient left the hospital. It is a question, of course, whether the operation will not produce abortion. This has occurred in one of the three cases which have come under my observation. In only one of the three was it known, at the time of the operation, that the patient was pregnant. The second case was operated upon at the Johns Hopkins Hospital when the patient was only a few weeks pregnant, and she subsequently came under my care. She made a good recovery, and did not abort, in spite of the fact that she was an epileptic and fell out of bed several times while in a fit. In the third case it was recognized that the woman was pregnant the moment the abdomen was opened. She had been an invalid for ten years and sterile, so there was no suspicion of pregnancy. The adhesions which bound the uterus back were broken up, and the uterus

brought up into position and stitched to the abdominal wall. The patient aborted three or four weeks later, apparently as a result of the operation. Upon entering the hospital she stated that she had missed a period.

Dr. Horace Tracy Hanks.—This paper is of vast importance to the gynecologist, especially as the author does not recommend the operation except as a last resort. In most cases, as he states, reduction of the incarcerated uterus is possible with one cutting. Always attempt treatment by posture and proper manipulation under thorough etherization.

Dr. A. Lapthorn Smith, of Montreal.—I can record one case of incarcerated pregnant uterus due to an ovarian cyst. The diagnosis was made by three of my assistants, and I operated in order to remove the cyst, the fact that the patient was pregnant not being recognized. They were forgiven for making the mistake, for the uterus was found to be doubled upon itself. I made the best of the state of affairs and stitched the uterus to the abdominal wall. The patient made a good recovery, and went on to full term.

Dr. Philander A. Harris, of Paterson, N. J.—I have one case to report which occurred eleven months ago at the Emergency Hospital in Passaic. The patient had a large tumor which extended well up into the hypogastric region. The uterus was also large. I made every effort to reduce it with and without anæsthesia and with the aid of posture, but without success. As the patient had some fever and evidences of beginning peritonitis were present, nothing further was done at the time. Four days later it was found upon examination that the uterus was in its normal position, in spite of the fact that it had been incarcerated for ten days or two weeks prior to this time. Whether the efforts employed to replace the uterus had any effect in causing it to return to its proper position, I am unable to say.

Dr. Malcolm McLean, of New York.—Three years ago I reported to the New York Obstetrical Society a case of incarcerated pregnant uterus, the details of the case being so peculiar that I dwelt upon them at some length. The woman was four and a half months pregnant, and the uterus was held down in the true pelvis. There was a tumor in the left iliac region extending up to the iliac spine. I operated to remove this tumor, and found

that it was one horn of a bicornate uterus. The condition was the result of nature's efforts to get out of a bad fix, a hernia having been formed by one horn of the uterus. This was so extensive that it was with the greatest difficulty that I was able to free the other horn of the uterus, in which pregnancy had taken place, by the method so graphically described by Dr. Mann. There were also many adhesions. The most peculiar feature of the case is that, the moment that the incarcerated horn was liberated, the uterus assumed its normal globular shape. The woman went on to term, and normal delivery occurred.

Dr. Mann, in closing.—In regard to the use of an anæsthetic in attempting to reduce the incarceration of the uterus, I took it for granted that it would be understood that narcosis was employed in the case referred to before operation was resorted to. I said that after *all* methods of reduction had been tried without success, the abdomen was opened. Naturally, this included the use of an anæsthetic and posture. Otherwise the case would not have been one of irreducible incarceration of the uterus.

In regard to fastening up the uterus, it would never occur to me to do this. It was so difficult to get the uterus up that there was not the slightest fear of it resuming its former abnormal position in the hollow of the sacrum.

As to the remark made by Dr. Hanks, the operation should not be undertaken except as a last resort—to save the fœtus and avoid emptying the uterus. It is only justifiable under extreme circumstances.