In Defence of the Pessary.*

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In the course of this year two papers have appeared on the subject of the use of the pessary, the one entitled "On the Application of Pessaries and their Dangers,"† the other "Pessaries: Their Uses and Limitations."‡ Both of these contain statements which challenge criticism.

With regard to the *dangers* of the pessary it would be quite as much to the point to speak of the dangers of the scalpel. The dangers arising from the use of the pessary are due to ignorance, want of skill, or carelessness on the part of the practitioner, or to ignorance and carelessness on the part of the patient. The practitioner is either ignorant of the principles of its proper use, or deficient in skill in employing it, or careless as to the instructions he gives the patient; or the latter being wholly ignorant of the subject, is careless in carrying out her instructions.

The authors of these papers seem to have brought together the *possibilities* of danger as a peg on which to hang a plea for surgical interference, but they are unable to produce any evidence in support of their argument. They are much taken up with "the pathological conditions (in the words of one of them) which contraindicate the use of any pessary, and where its presence constitutes a distinct danger." The use of a pessary under these circumstances must surely be regarded as an indication of gross incompetence.

With regard to their "uses and limitations" I am in accord with much of the argument of the writer, but when he speaks of them as a *necessary evil* I entirely disagree with him. If this be correct, then, any operation or method of instrumental treatment is a necessary evil—even the wearing of a set of false teeth. Now there are only four conditions affecting the uterus to which the use of a pessary is applicable. These are uncomplicated retroversion, anteflexion, retroflexion and prolapse. Perhaps I ought to include elongation of the cervix; but as it is usually associated with some

* Read at a meeting of the Edinburgh Obstetrical Society, December, 1904.

† Macnaughton-Jones, *Brit. Gynæcol. Journ.* and *Med. Press and Circular.*

‡ Giles, *Med. Press and Circular.*

prolapse of the whole organ it scarcely deserves to be erected into a separate class. The enumeration of the various pathological conditions that may be associated with these serves only to obscure the subject, for they, not the displacement, become the subject of our solicitude. But the examples of the *abuse of* the pessary enumerated by this author are quite to the point. When, however, he says that "properly fitting pessaries, rightly applied, have enough to answer for in the way of drawbacks and complications," I find another point for disagreement.

In Schultze's work on "Displacements of the Uterus" 66 pages are devoted to the pathology and terminology, yet these subjects can, for practical purposes, be disposed of in a few lines, or at most, pages. It may seem trifling with the subject to ask the question, "What is a displacement?" But it is not so, as a proper answer to this question is absolutely necessary. A displacement, properly so called, is a departure of the uterus from its normal *position*. Hence there is in reality only one form of displacement, viz., retroversion. I am glad to find that there is a general acknowledgement that anteversion of the uterus is not a pathological condition *per se*. This is the position I took up nearly a quarter of a century ago, but it has not yet met with acceptance by the author of the first paper. The normal position of the uterus with regard to the axis of the vagina is one of anteversion, and to speak of anteversion as a displacement is obviously incorrect. Amongst writers on this subject generally—and this is characteristic of the two above referred to—no distinction is drawn between *retroversion* and *retroflexion*. Schultze, in one of his tables, groups these under the head of retroflexions, and in another brackets them. Now a retroversion means a *turning* backwards, and a retroflexion a *bending* backwards, of the organ. This is a distinction with a mighty difference, and ought to be kept clearly in view. No work with which I am acquainted, with the exception of that of Hart and Barbour, clearly observes this distinction. Others use the terms as being synonymous. Hence we find the greatest discrepancy as to their relative frequency. This is seen in a table of Schultze's in which he gives, under the head of retroflexion the experience of various authors, the frequency ranging from 12 to 198 "per 1,000 cases of diseases of women," from 200 to 297 "per 1,000 displacements," and from 84 to 550 "per 1,000 flexions."

Strange to say, the distinction between *anteversion* and *anteflexion* seems to be observed. Of the first Kolb says, "As a matter of course anteversion *cannot* attain a very high degree," To this I may add that any exaggeration of this, which I call the normal condition will be due to a pathological state which then becomes *the* point for

consideration. I do not know why so many gynæcologists of the day should persist in saying that anteflexion is the normal form of the virgin uterus. It is not so described in Quain's anatomy, but is represented as being quite straight. No notice appears to have been taken of the special investigation of Bandl, who as the result of *post-mortem* examination of a large number of cases arrived at the following conclusions:—"In the new-born the uterus was partly straight, partly in slight anteflexion, lying in the pelvic axis." "In older children, in whom the body of the uterus has acquired greater firmness, that organ is far more frequently found straight." "The straight form of the uterus is frequent as compared with the anteflexed."

A great deal has been written about the causes of uterine displacement. I particularly refer to retroversion. I do not see how any knowledge of this kind can help us in the least in the matter of treatment. We are not called upon to prevent displacement, but to remedy it, except in the case of a patient who has been the subject of displacement previous to a pregnancy which had been brought about perhaps, or at least aided, by the application of a pessary—of which I have seen many examples. The surgeon is not aided in his treatment of a broken leg by a knowledge of the way in which the fracture has been sustained. The only opportunity for practising preventive treatment arises when the subject of a retroversion has become pregnant while wearing a pessary, or was known to have a retroversion at an early stage of pregnancy. In such a case the patient should not be allowed to lie on the back during the puerperium and the earliest opportunity should be taken to ascertain the position of the uterus. Such a case has come under my notice while writing this paper. Some few years ago I found the patient to be the subject of a very bad laceration of the perineum, a large rectocele, a smaller cystocele and a well-marked retroversion. I restored the perineum with a view to a subsequent pregnancy, and applied an Albert Smith-Hodge's pessary, which gave immediate relief to very distressing symptoms. In January last, after the lapse of about seven years and believing herself pregnant, she again consulted me, earnestly desiring that I should produce abortion because she was afraid she might have a repetition of her former trouble. I comforted her on this point, instructed her not to lie on her back after delivery, and wrote to her medical attendant. My instructions were rigidly carried out and when she came to me at the end of three weeks I found the uterus in perfect condition. My intention was to apply a pessary if the uterus showed any sign of

becoming retroverted, for if taken at this early period a cure can be confidently anticipated. That a retroversion is sometimes caused by a fall on the buttocks, or even on the face is unquestionable—of both of these I have seen several examples—but I do not see how this knowledge affects the treatment. We may tell women that they must avoid falling in either of these ways, lifting heavy weights, or straining at stool. But probably in 999 cases out of a 1,000 this advice would be useless. Hence disquisitions on etiology appear to me to be labour lost.

A knowledge of the frequency of displacement, or malformation in the female population is obviously unattainable. But we can form an approximate idea of their comparative frequency. According to my experience the three states of retroversion, anteflexion and retroflexion stand in the order of frequency as I have named them. Retroversion with anteflexion is so very rare that it may be regarded as a curiosity and scarcely deserving of being erected into a separate class. I have seen but very few cases in an experience of 40 years. Two of these are recorded in my little book on the "Use and abuse of Pessaries," and as far as I know they were the first observed.

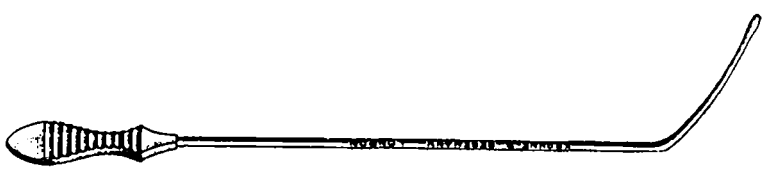
Now, given a case of uncomplicated retroversion, in which the uterus is perfectly mobile and capable of being raised into its normal position, either bimanually or by means of the sound I unhesitatingly assert that the only legitimate treatment is that by a properly adapted pessary. I protest against the statement of a well-known operator that "the only place for the pessary is the back of the fire." Such a statement can only be the outcome of profound ignorance of the subject. The mania for surgical interference, which characterises the present-day gynæcology, the ignorance prevailing with regard to the principles of the treatment by the pessary, and the want of skill in its application, have blinded men to the justice of this simple proposition which I have laid down, and we read of hundreds of cases of operation by individual operators, such as shortening the round ligaments from without or from within the peritoneal cavity, ventro-fixation and vagino-fixation. If I could have brought my conscience to the point of persuading my patients to submit to any one of these operations, I also should have been able to reckon them by hundreds. But I have never done so. Alexander's operation never appealed to me because of the fact that when the uterus is pulled down, the last structures put on the stretch are the round ligaments, while ventro-fixation placed the uterus in an unnatural position, and vagino-fixation appeared to me an outrage on common sense. On the contrary, there is no branch of my work

that gives me more satisfaction than the use of the pessary in cases of uncomplicated retroversion of the uterus, and for these reasons, viz.: the absolute *absence* of danger, the relief which it gives in all cases when properly applied, and the prospect of cure in a large majority of the cases. It is no valid argument against its use that the pessary has to be worn for many years. The same objection may be urged against the wearing of a set of artificial teeth, and with much more justice.

The time required to effect a cure will be in proportion to the duration of the displacement. Striking examples establishing this proposition are afforded by the cases of recent occurrence to which I have already referred, viz., from falls, and in which relief was immediately obtained and a cure effected within a year, as well as in the following case very briefly related. A former patient of mine (1890) was cured of uterine congestion, and a year after the cessation of treatment bore her first child, after having been sterile for four years. After several years of widowhood she married again, and being desirous of having at least one child more—for her husband's sake—again sought my aid in January, 1896. The uterus was in perfect position and free from congestion, but the cervix was hard and the canal contracted. Under a course of treatment by graduated bougies the canal became patulous, and in due time she became pregnant. She had a very good confinement, but immediately on getting up she began to suffer great discomfort and even pain in the pelvic region. An appeal to her medical attendant was without avail, and as soon as she could travel she came to town. Examination revealed a well-marked retroversion. The application of a pessary gave her immediate relief, and in a year I removed it. Six months afterwards the uterus was in perfect position.

The majority of my patients come after many years of suffering, some—I may say most—of them having worn pessaries (up to as many as seven) of various kinds and sizes, others only subjected to medicinal treatment. I have a large number of pessaries duly labelled, as examples of completely successful treatment, *i.e.*, cure; but I have, or have had till recently, a very much larger number illustrating unsuccessful treatment, removed from patients to whom I have been able to afford relief. These examples illustrate the ignorance prevailing with regard to the principles of treatment. To say that a man who puts a pessary into a woman's vagina merely because she has symptoms referable to the pelvic region is ignorant of first principles is a self-evident proposition. And yet how many of these cases have I seen! Given a genuine case of retroversion it

is necessary to understand the principles of treatment. In all cases of retroversion there is a certain amount of descent of the uterus. In a well-marked case the cervix will be found close up behind the pubes, in the axis of the vagina, with the os pointing to the outlet, so that the examining finger passes straight into it (if dilated). In extreme cases the os even points upwards as the patient lies on the back. The vagina is shortened in proportion to the amount of descent. The first principle, then, is to restore the uterus to its normal position, and despite all that has been said against the use of the sound, I maintain that it is the best means for this purpose. In a few cases, when the abdominal walls are very thin and lax, it may be possible to effect the restoration by the bimanual method, but even in these the proceeding gives much more pain than the sound. By means of this instrument the uterus can be raised till the fundus touches the anterior abdominal walls without the possibility of injury, provided the cervix be supported by the finger guiding the sound. For this purpose the sound should be well bent, not curved near the point as is usual, but as in the illustration. In all cases it



is essential that the bladder should be empty. Then the sound is withdrawn, and, while the cervix is pressed backwards and the fundus forwards, the intestines are pushed well down behind the uterus, and the organ is left in a state of exaggerated anteversion. The pessary is now applied, and if the sound again pass in the normal direction we have proof that the normal position is maintained. I may here add that this exaggerated position of anteversion has never, in my experience, caused any symptoms.

While it is of the first importance that the uterus be thus placed in its proper position, it is equally necessary that the form of the vagina should receive our attention. The restoration of the uterus to its proper position restores the vagina more or less to its normal length. Now the object of the pessary must be to maintain these two effects. The mode of action of the pessary has been so often described by Goodell, Schultze and others besides myself, that I need not dwell upon this part of the subject. To put in a pessary without first restoring the uterus to its proper position, in the hope that it

will effect that object, has been sufficiently condemned by other writers. Schultze is very emphatic on this point, for he says "no pessary in existence can do this; the normal position must first be restored."

Now it must be remembered that the vagina is a collapsed tube—not an open tube or pipe as authors continually represent it even at the present day—flattened antero-posteriorly, with the two surfaces in close apposition and closely embracing the cervix. This is admirably illustrated by Hart and Barbour. Therefore it follows that any instrument which separates these surfaces to that extent distorts the vagina. Hence also it follows that as it is not possible to devise an instrument that will obviate this entirely, the best is that which distorts it the least. The forms (and names) of the pessaries that are now, or have been in use, are legion, and while much ingenuity is shown in their construction, very little judgment is exhibited. Careful investigation has shown that the form of the vagina may be represented by a thin section through the middle of a pear, the stem end being towards the vulva.

The instrument then which most nearly meets the requirements of the case is the Albert Smith modification of Hodge's pessary, than which I do not believe it possible to devise a better, and when made of material that can be readily moulded to suit the necessities of each case we have all that we can desire. The figure-of-eight pessary has these disadvantages, that if the cervix be enlarged, as it frequently is, it gets strangulated in the posterior opening, and the walls of the vagina are kept too far apart where the limbs cross one another favouring the accumulation of discharge. This applies to all the others in varying degree. I think I am justified in calling the "ring" pessary the "abomination of abominations." Yet I am told that it is sold by the gross where all other varieties are sold by tens. From its tendency to resume its circular form the effect of this instrument is to shorten the vagina, and thereby continue the descent of the uterus, and to keep the naturally opposing surface widely asunder, etc. Hence we need not to be surprised that the men who use this instrument never meet with a case of cure, and therefore form a low estimate of the value of the pessary. It is *impossible for a ring pessary to cure* a simple case of retroversion. Until recently I had a very large collection of these pessaries ranging in size from the smallest to 4½ inches in diameter. Their removal was always attended with the escape of a more or less copious discharge, often offensive. I am surprised to find that this form still finds

favour with the writers of the two papers I have referred to at the beginning. Under the same condemnation comes Fowler's pessary, and if it be possible to pass a heavier sentence I select the cup and stem pessary for it. I have quite recently come across two cases in which this instrument caused intolerable suffering. In one of these only was there any displacement, and in this case the application of a properly fitting Albert Smith-Hodge gave immediate relief, notwithstanding intense uterine congestion.

If ignorance of first principles be answerable for much of the failure to afford relief, or effect a cure by the adaptation of a pessary, want of skill is no less so. From a combination of the two it results that the pessary is often put in doubly reversed, with the infliction of much unnecessary pain. This had so frequently occurred in the case of patients coming from the country that, some years ago, I had to resolve that unless the patient could give me the opportunity of ascertaining the cause of any failure to give relief, I would not undertake the case. Quite recently the breaking of this resolution was attended with distressing circumstances. The patient was a young woman, the mother of one child. She had not been well since the birth of that child, six years ago, suffering from more or less constant pain in the pelvic region, from menorrhagia (for which she had been twice curetted), from dysmenorrhœa, headache, sleeplessness, thoughts of suicide and gastro-intestinal troubles, including obstinate constipation. The application of a cup and stem caused her intolerable suffering, and she was at last told that she must make up her mind to be an invalid for the rest of her life. It was under these circumstances that she consulted me. Examination revealed the existence of retroversion, with general enlargement—probably sub-involution—intense livid congestion of the enlarged cervix, and "erosion" of the circle of the os. After a course of treatment, including the use of a pessary, she had improved so much in every respect, and the uterus was in such excellent position that on one occasion I sent her home without the pessary—as a test. Three days afterwards she began to have her old symptoms, and at her request, though with some misgiving, I sent her the pessary. A great deal of pain was inflicted upon her in the effort to introduce the pessary by means of a speculum, and otherwise. After its introduction not only was there no relief but an actual aggravation of the symptoms. In a state of despair she telephoned to me her condition, and I had to ask her to come up at once—a distance of nearly 200 miles. I found the pessary doubly reversed. Its re-application, without any pain, at once relieved her, and now,

unconscious even of its presence, she looks to the future with confidence.

The authors of the papers referred to are, as I have said, still in favour of the ring pessary. The former actually gives an illustration of an impossible state of things with the ring *in situ* and the latter specifically says, that "in uncomplicated cases of cystocele *and rectocele* a rubber ring pessary usually answers best, whether there be cystocele alone, a rectocele alone, or a combination of the two." I may at once say that a pessary applicable to the treatment of a rectocele has not yet been devised, nor is likely to be, and the only effectual treatment is the restoration of the perineum. It is quite different, however, in the case of cystocele. For this condition we have a perfect support in the diaphragm pessary, which was introduced to the notice of the profession many years ago in my little book, but which appears to have been overlooked. Here is a specimen or illustration.

With this instrument I have obtained excellent results in cases of cystocele and elongated cervix. In one case of the latter in which the cervix had passed through the vulva a lasting cure was effected. The only difficulty attending its use is that it cannot be kept in stock and a model has first to be made out of a Britannia metal pessary with elastic bands across. From this model one is made of vulcanite.

There is a general agreement as to the precautions that should be observed in the use of pessaries. That they are not in every case attended to ought not to be charged against their use, but against their abuse. If these precautions were observed we should not hear of "injuries due to neglected pessaries."

As far as present appearances show it seems hopeless to expect that the age of anteversion pessaries will soon be at an end, or of vaginal pessaries for anteflexion. Yet a moment's consideration of the anatomy of the parts ought to convince any unprejudiced mind that it is impossible to influence for good either of these conditions. Thus anteversion beyond the normal will be

due to something behind the uterus pushing it forward and in such a case the anteversion claims no attention. Anteflexion is in no way influenced by the frequent distension of the bladder, and it is an utter impossibility to exert any pressure on the fundus owing to the intervention of that viscus. As I have already said, anteflexion is not a displacement but a malformation, and must be treated from within. For this purpose the intra-uterine stem—preferably Meadow's combined stem—is often of great service. But seeing that anteflexion *per se* is not necessarily a cause of symptoms until it becomes associated with some degree of obstruction to the escape of the menstrual flow through narrowing of the canal, this instrument now seldom finds a place in my armamentarium. This narrowing of the canal may be only temporary, that is to say during the physiological congestion which characterises the menstrual period, or may be permanent through hyperplasia of the uterine tissue, in which case the internal os will be found to be extremely rigid, so much so as to resist the distensile action of a large laminaria tent for 48 hours. Such a tent I have illustrated in my book—and I have seen many of them when dilating for the purpose of curetting. In these cases the process of dilatation is often accompanied by retching or even vomiting, as it is in the use of graduated bougies. These cases are not suitable for the stem pessary but for gradual dilatation. Did time permit I could give some striking examples of this effect, and I may now state that I have long given up any cutting operation in their treatment.

When it is said that "at their worst pessaries are capable of producing serious injuries and at their best they have inherent drawbacks," I would ask of what method of treatment cannot the equivalent be said, and with far more justice? The writer of these words has drawn up the following indictment against them, viz., "that there is a tendency to set up irritation resulting in constant leucorrhœa *(which I deny)*, and entailing the necessity for regular douching; there is the necessity for examination at more or less frequent intervals *(to which I give a qualified denial)*, which most women naturally find objectionable *(yes, when as I have heard, some men are in the habit of removing the pessary for every menstrual period)*, there is the uncertainty of results, and, lastly, in favourable cases there is the prospect of a woman having to wear a pessary for ten, fifteen or twenty years." Apart from the fact that this indictment shows a lamentable want of appreciation—to put it in the mildest way—of the proper use of the pessary, how does this indictment compare with that which can be brought against his

"more excellent way," viz., either of the various operations which have been devised, and are now so frequently resorted to for the relief of uncomplicated retroversion? I refer you to the recent report of Professor Oui, read before the recent Congress of Gynæcologists at Rouen, on the influence of these operations on pregnancy alone.

Now, I am not aware that there is on record a single case in which a woman has lost her life through the use, or even the abuse of a vaginal pessary. On the other hand, what a tale of disaster could be written with regard to the operations I have referred to! Failure in every respect has attended them; immediate failure by death of the patient; failure to effect a cure, or relieve the symptoms; abortion as the result of the imprisonment of the uterus; rupture of the uterus from the same cause; the necessity for Cæsarean section in the cases of women who have previously had normal confinements, and in a considerable number of cases return of the displacement after a succeeding pregnancy; and finally the need of a second operation to remove the effects of the first. Do not suppose that I am drawing upon my imagination for all this. It is all too true. I say that an operation which is certainly not one of necessity which cannot even be said to be one of expediency, which involves so much risk of life and actual disaster and which places the uterus in an *unnatural position* is not a justfiable one. At least that is the opinion I have long held, and now with increased tenacity in view of extended results; for my estimate of the sanctity of life has prevented me from adopting the practice even in a single case, seeing that I have been able in a vast majority of cases, to afford relief by a perfectly harmless procedure. Some of these operations have already been rejected, notably Mackenrodt's operation of vagino-fixation—an example of "the remedy being worse than the disease"—and each individual operator declaims against the methods of the other.

When a retroversion is complicated by adhesions, inflammatory states of the appendages, or tumour in the uterine wall, it is not the version that calls for treatment but the complicating condition. Yet say that an operation which is certainly not one of necessity, which have met with unexpected and most gratifying success from the use of the pessary. Did time permit I could give the details of a case of retroversion complicated by a fibroid tumour of small dimensions, just short of being imprisoned in the pelvis, in which a pessary retained the uterus in position until the disappearance of the tumour coincident with the menopause left the uterus in its normal place. This patient wore the same pessary (Britannia metal) throughout.

Had this patient any reason to complain of having had to wear a pessary for more than ten years? I trow not.

The pessary is an important aid in the treatment of sub-involution so often associated with, if not due to the retroversion. In the case of retroflexion properly so called, or as I have defined it, no vaginal pessary can be of any service in undoing the flexion, for the reason that it is impossible to afford direct support to the fundus by its means. In these cases, which, by the way, are very rare, the instrument I use is Meadow's compound stem, and it is remarkable that menorrhagia, which so frequently accompanies this condition, is not only not aggravated, but actually benefited by it. That many cases of retroversion of long standing have some amount of flexion super-added is unquestionable, from long-continued intra-abdominal pressure on the anterior surface. But these are essentially retroversions. This posterior flexion appears to me to constitute a strong argument against the current doctrine that anteflexion is the normal form of the uterus. In a case of true retroflexion a vaginal pessary simply aggravates the flexion by doubling the uterus still further upon itself.

Now arises the question, Of what material should the pessary be made? The rubber or celluloid-covered wire, the vulcanite, and Britannia metal, all find their advocates. The pessaries I have had to remove most frequently and accompanied by the most offensive discharge have been the first-named. The idea of putting a cushion on the posterior crossbar, filled with air or glycerine, to support the fundus not only shows an ignorance of the action of the pessary, but is a physical mistake; for, in a short time, the cushion collapses and presents a horribly corrugated surface, with what result I need not describe. I am informed that these cushions are now filled with gelatine, but that does not alter the principle. The vulcanite is open to only one objection, viz., that it is very difficult to alter the shape, and, as Marion Sims said, "the man who is not a mechanic should not trust himself to use a pessary." I have tried the celluloid, which finds so much favour with Schultze and his followers, but others as well as myself have found that it does not retain its shape unless nearly straight. The most suitable and convenient material, according to my experience, now extending over a period of about forty years, is the Britannia or white metal. The shape is most readily altered and is retained, and the metal itself offers this advantage that it gives notice of the presence of any irritating muco-purulent discharge, by becoming more or less black. It is also very easily cleaned and polished, and can be worn for years. Were

it not for the difficulty of moulding it the best material of all would be aluminium on account of its extreme lightness and non-liability to corrosion by any discharge. But this difficulty and the cost militate against its more general use.

I have now shown that the pessary when properly used, and not abused, involves no danger whatever, but is worthy of our full confidence, that the charges that have been brought against it cannot justly be sustained; that in its results it compares most favourably with the operations which have been substituted for it, and that it is an entire misrepresentation of the case to say that "the operative measures" to which I have referred "do all and more than all that pessaries can do without their manifold drawbacks and risks."

If I had done nothing more than afford the relief which the pessary has enabled me to give I should now feel that my professional life had not been ill spent, and if I have failed in some cases I have at least the satisfaction of having done no harm. I may have used some strong expressions in the course of this communication. If I have done so it has been from a sense of duty, and if I had a hundred tongues I should use them for the purpose of trying at the least to put a curb upon the frequency with which the operations to which I have referred are performed.