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## RETROVERSIONS: HOW MAY THEY BE PREVENTED\*

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**T**HE necessity for a critical study of retroversions, both from a gynaecological and an obstetrical standpoint, is apparent not only by reason of their frequency but also by reason of the large output constantly maintained from the field of obstetrics into the domain of gynaecology.

The small proportion of the retro-displacements that are congenital in type, or developmental, give rise to the fewest symptoms and are most amenable to treatment.

By far the largest proportion occur after childbirth, and it is this class of retro-displacements that chiefly concerns us all,—specialists and general practitioners alike—for, so long as the general practitioner undertakes the care of obstetrical cases, the problem must be his as well as that of the specialist. As to the frequency of these lesions, J. Whitridge Williams in his article—“Has the American Gynaecological Society done its part in the advancement of obstetrical knowledge?”†, makes the statement that at least one-quarter of all women develop retro-displacement following their first confinement.

This statement stands undisputed and is sustained by the personal testimony of other obstetricians; most of them agreeing that the proportion is at least 1-5. Surely this is not a satisfactory result to contemplate; that a physiological process such as child-birth should eventuate in a serious lesion of such vital import, not only to the health of the patient, but also in relation to her future powers of reproduction.

The contrast in the clinical picture of a woman emerging from her confinement with backache, dragging sensations, inability to walk and numberless nervous symptoms characteristic of retro-displacement and the well woman with all the buoyancy and health that go with the unconsciousness of a normal pelvis is too obvious to be dwelt upon.

Wherein lies the fault for the frequency of these lesions? Is it due to faulty conditions within the woman herself? Is it due to lack of care on the part of the obstetrician or is it due to faulty technique in the care of the patient?

A review of the many elements entering into the situation may not be without profit.

\*Read before the Homœo. Medical Society, County of N. Y.

†Journal of the American Medical Association, June 6, 1914.

Taking up the consideration of the patient, the woman herself,—is she showing an inability to meet the strain of pregnancy and child-birth without running the risk of permanent injury?

There is no doubt that the woman of the present time bears a heavier burden than her sisters of several generations ago, by reason of the strenuous age in which we live and in which she necessarily carries her share of the strain.

Also anatomically the difficulties are greater by reason of the larger size of the child's head, due to increased intellectual development and the female pelvis that has not increased in a corresponding ratio to meet the larger foetal head.

Besides which she suffers from the defects and handicap of the upright posture—wherein the evolution of the species—the angulation of the pelvis has brought about a much more difficult mechanism of the foetal head with possible complications attending.

Added to these difficulties is the unfortunate mode of modern dress, which makes the waist a fixed point for the support of clothing—whereby the normal diaphragmatic excursions are limited, resulting in laxity and loss of muscular tone of the abdomen and pelvis. The large increase of occupations for women involving long continued standing has also a deleterious effect.

These facts cannot be ignored in relation to women's child-bearing power but, notwithstanding all of this, it must be conceded that the young women of the middle classes of to-day show a better standard of physical health and resistance than their mothers did, by reason of their larger out-of-door life, physical activities and more intelligent care of themselves.

Her handicaps are not sufficient in themselves to account for the post-*puerperal* lesions. It may be that she shows an increased susceptibility to the derangements incident to child-birth. If so, all these elements must be recognized that the art of obstetrics be adjusted with greater nicety to meet her needs.

As to the relation of the obstetrician to the patient, has he given all the care possible to the patient? Considering the difficulties of environment under which he has had to labor and the arduous nature of the specialty, many advances have been made.

The patient is now receiving better *ante-partum* care and she is being brought to the time of delivery in a more normal condition by reason of the supervision of her methods of living. At the same time, *ante-partum* examinations have disclosed faulty positions and pelvic abnormalities before labor set in.

In the conduct of labor, there is greater accuracy shown in the details of the aseptic technique, and more careful coaptation of the muscular structures in the repair of pelvic floor lacerations. These methods have become quite thoroughly standardized.

In the management of the *puerperal* period, there is room for discussion and possible criticism.

The period for keeping the patient in bed has increased from ten days to two weeks. The patient is kept in the horizontal position with frequent lying over upon the abdomen, and an occasional knee and chest position to aid in forward movement of the uterus.

Insistence upon post-partum examinations has revealed a discouraging array of displacements and what is still more disheartening, the three weeks' examination has shown many times the uterus to be retroverted that had been normal at two weeks' post-partum.

The question naturally arises, is the passive treatment of the puerperal period the best method for the patient? Does the loss of the general muscular tone, induced by the prolonged rest, favor a similar relaxation in the involuting pelvic contents? Can better results be attained by opposite methods of increased activity?

Before answering, let us consider the physiology of the human uterus.

Dr. Chas. C. Lieb \*has recently conducted a series of most interesting experiments upon the excised human uterus and tubes. Segments of the uterus were excised and suspended in an oxygenated Ringer solution at 38°C. The movements of the muscles were recorded by a lever of the first order on the smoked paper of a slowly turning kymograph. The records show that contractions of the external coat of the uterus were slow and powerful at the rate of ten to sixty per hour. In the pregnant uterus the movements were of two types—first, the simple waves and second, large coarse waves on which were superimposed smaller contractions. These coarse waves were due to change in tonus, and the waves varied from sixty to seventy-five an hour.

Movements of the oblique fibres of the middle coat were also recorded. The movements of the longitudinal and circular fibres of the fallopian tubes were much faster than those of the uterus, one hundred and twenty to two hundred per hour, assuming a slower and more powerful character during pregnancy.

He further showed that these contractions were due to impulses within the organ itself, probably within the muscle fibres.

Kehrer's experiments upon the living uterus in the human body were also most interesting. He has shown in the pregnant and post-partum uterus that, besides the normal ascent and descent of the uterus during respiration, there were three kinds of normal uterine contractions taking place.

I. Pendulous movements corresponding to those of the intestines and probably present in the tubes and ligaments, as well as in the body of the uterus.

II. Tonus waves or variations in tonus.

III. Contractions of different types, true peristaltic waves besides simultaneous and rhythmic contractions of the whole uterus.

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\*The Physiology and Pharmacology of the Excised Human Uterus.  
American Journal Obstet.

This rhythmic action, that is shown to be characteristic of the uterine muscle, is undoubtedly a powerful agent in bringing about a normal involution during the puerperal period.

With strong contractions of the uterus and tubes, the uterine sinuses are closed, venous stasis prevented, the waste products rapidly eliminated and the pelvic organs return to their normal size and position, there to be retained by their normal tonicity.

Any influence interfering with this process means impaired result, a subinvolved uterus with relaxed ligaments predisposing to displacement.

It can readily be seen how close the relation must be between a good general muscular tone of the patient and the uterine tone.

The group of obstetricians at Freiburg have seized this idea and have put it into practical effect by developing a technique for an active puerperal period instead of a passive one. The technique briefly is as follows:—In from six to eighteen hours after delivery passive movements are given the patient by the nurse. These consist of flexions and extensions of the upper and lower extremities and of the trunk. These exercises are repeated twice daily thereafter, changing to active resistant exercises and increasing the variety to the time limit of ten minutes for each session. It is interesting to place the hand upon the fundus of the uterus while the patient is receiving the resistant exercises and feel the uterus contract under the hand with the flexion and extension of the limbs.

On the second day of the puerperal period, the patient is allowed to sit up in bed, the third day she is out of bed, after which she sits up longer each day until she leaves the hospital on the sixth or seventh day. The contra-indications for the active puerperium are heart lesions, lacerations, marked anemia from undue blood loss or any inflammatory condition.

Under this active treatment, the patient is in better condition with the uterus better involuted in one week than she was in two weeks by the passive method. Post-partum examinations show a well involuted uterus in normal position. Gauss and Knipe both report entire absence of retroversion in their series of cases.

Embolism, that most dreaded of puerperal complications has not occurred in any of the series with this method and, if a good tonicity of the uterus is maintained and no infection has taken place, it is impossible for it to occur even with activity.

This active puerperium does not mean that the patient is to receive less careful supervision from the obstetrician, during the period of involution. On the contrary, during this time, she is to be guarded from over-exertion, heavy work and nervous strain. In short there must be a "well-controlled activity" and carefully regulated periods of exercises followed by periods of rest.

Considering that the results reported are so favorable and so far in advance of those achieved by our methods, I would make the sug-

gestion that the method be carefully tried and that series of cases be reported. To be of value, these reports must be accurate, a record being kept each day of the height of the fundus, until it has returned to the pelvis, and also the post-partum examinations of two, four and six weeks.

By this means we can check up results and evolve a technique that will, in a large measure, eliminate post-partum retro-displacements. All of this means more work to the already over-burdened obstetrician, and the only solution is hospital care for obstetrics, the same as in surgical cases.

With a well trained obstetrical staff, among whom much of the routine work can be divided, the obstetrician will then be in a position to solve some of these important problems. To realize how important and far-reaching they are, one has but to glance over the operations posted daily at the Academy of Medicine to see how frequently some operation for the relief of retro-displacement is bulletined. In the last month, out of 631 gynaecological operations posted, 133, or 21%, were for retro-displacements and prolapse.

When it is considered that this is a small number of all the operations performed during the month in New York for retro-displacements, and that only a certain proportion of patients suffering from retroversion come for surgical relief, we can then realize the numbers of patients having the lesion—and the expense, the loss of time and efficiency, as well as the suffering involved, all of which are largely preventable.

When we go a step further we realize that, notwithstanding the numerous operative procedures devised for the relief of retroversion, not one has been evolved that restores all the different parts of the pelvis anatomically to their normal relation such as existed before the displacement occurred.

Though there may be a symptomatic cure, the result is obtained either by a readjustment of the uterus, an interposition or suspension; or an operation is made upon some of the ligaments, unfolding them, shortening them or bringing them in other structures, but none of them fulfils the mechanism of the normally constructed pelvis, hence the prevention is more rational than the cure.

CONCLUSIONS. I. Post-puerperal retroversions are due to a general sub-involution of the whole pelvic contents, a general lack of tonus and not to the weakness of any special ligament or organ.

II. Institute an active instead of a passive puerperium.

III. By increasing better general muscular tone, the uterine tone is also increased.

IV. The prevention of post-puerperal retro-displacements is made possible by a well managed active puerperium.