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INCARCERATED RETROVERSION ASSOCIATED WITH PREGNANCY*

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THE patient was thirty-four years old, married two years and had never been pregnant. She began to menstruate at the age of twelve years; her menstrual periods were regular every twenty-eight days, lasting three days, moderate in amount. Last period September 19, 1927.

On November 1, she began to feel nauseated and vomited occasionally. This continued until the middle of November. After that she felt well until the first of January. The patient then noticed that the abdomen was beginning to swell, and at the same time she felt distressed and was unable to void, although she had the desire to do so. Shortly thereafter she voided a small amount with much pain, but with no straining. The patient took some spirits of niter and hot douches and felt better for a short time. The symptoms returned. She then consulted a doctor who prescribed urotropin, which for some unknown reason improved the condition for a few days, and then the difficulty in voiding and pain returned.

Three weeks later the swelling increased. She then consulted one of the city clinics, where she was given some tablets and advised to have an x-ray taken to determine whether she had an ovarian cyst or was pregnant. The first x-ray showed a mass, no fetal parts. A uterosalpingogram was then attempted but could not be done as the uterus could not be injected.

On January 19, the patient applied for treatment in the Gynecological Department of the New York Post-Graduate Hospital. Her chief complaint at that time was distention of the abdomen, sharp pain all through the lower abdomen, and difficulty in voiding. She could void without pain or difficulty on lying down. She had no backache, no constipation or discharge and no pressure sensation in the

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back. The patient had to walk doubled over. Up to the time of appearing at our clinic, the patient had never been catheterized.

The patient stated that she had voided five minutes before getting on the table for examination. On examination the first thing noted was the swelling of the abdomen reaching about one inch above the umbilicus. The peculiarity of the swelling was the abrupt rise of the convexity from the superior border of the symphysis. A short metal self-retaining catheter was introduced and about 500 c.c. of urine was withdrawn. No very appreciable change in the swelling was evident. Not feeling satisfied with the result of this catheterization, the metal catheter was withdrawn. A soft rubber catheter was introduced and about 1500 c.c. more of urine was obtained. The swelling then largely subsided.

On vaginal examination, the first thing to meet the examining finger was a marked swelling just within the introitus on the posterior vaginal wall. On passing the protrusion and feeling for the cervix in the usual position, it could not be found. On deeper palpation, the cervix was found high up near the upper border of the symphysis, jammed hard against the under surface with the body of the uterus acutely retroflexed and in the hollow of the sacrum. The uterus was enlarged, soft and reached midway to the umbilicus and was evidently pregnant. An attempt was made to dislodge the uterus in the dorsal position but was not successful. The patient was then put in the knee-chest position and another attempt to dislodge the uterus manually was again unsuccessful. She was then admitted to the service of Dr. Walter T. Dannreuther and subsequently operated upon.

The abdomen was opened in the midline, the upper limits of the incision extending to the left of the umbilicus. The peritoneum was opened just below the umbilicus. A very much thickened, hypertrophied bladder was presented immediately beneath the wound. The bladder had been carried high up in the abdominal cavity by the pre-existing distension. The examining hand was carefully insinuated under the fundus of the uterus: the top reached almost to the level of the umbilicus, and an incarcerated sacculation of the posterior wall filling the culdesac and true pelvis was discovered. This was not adherent but was dislodged with difficulty. The elasticity of the uterine wall then allowed a return to the normal outline, and the culdesac was no longer distended, exerting upward pressure on the cervix. The left tube and ovary were lifted up, examined, and seemed to be normal. The bladder displacement was then seen to be due partly to an underlying intraligamentous cyst in the right broad ligament, which contained a large number of greatly dilated veins. The cyst was brought up into the wound as far as possible, walled off with laparotomy pads, and the contents evacuated. (This step was taken because the pedicle could not be exposed, owing to the pregnant uterus occupying so much space in the pelvis.) The contents of the cyst were of clear, mucinous, watery material.

The head of the cecum was then seen to be adherent to the posterior surface of the cyst wall and was easily separated. The appendix was also involved in the inflammatory exudate and was removed in the usual manner: clamping, ligating the meso-appendix; ligating and amputating the appendix with inversion of stump. The cyst was then clamped as low down in the broad ligament as possible and ligated with No. 2 chromic double interlocking mattress sutures. The pelvis and right iliac fossa were wiped dry and seemed to be free from bleeding.

Peritoneum was closed with No. 2 plain catgut doubled; fascia with No. 2 chromic catgut single; skin with black silk reinforced with three silkworm gut sutures.

Pathologic examination of the tissues removed showed chronic appendicitis and parovarian cyst.

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For five days after the operation it was necessary to catheterize the patient. The amount withdrawn was between 2 c.c. and 400 c.c. at each catheterization. On the fifth day the patient voided and continued to void thereafter without pain or discomfort.

She made an uneventful recovery and was up and about in eleven days. On February 24, 1928, she was examined. The fetal heart was heard midway between the umbilicus and pubis. The lower uterine segment was not flattened. The culdesac was free. Fetal movements and ballottement were easily determined.

On April 6, 1928, she was again examined. The cervix was back and pointed toward the hollow of the sacrum. There was no tension in the pelvis; the fetal head was palpable, and ballottement was easily elicited. The uterus reached midway to the ensiform cartilage. The patient was referred to New York Nursery and Child's Hospital for delivery.

On November 9, 1928, she again reported for examination. During that time she had given birth to a baby boy at New York Nursery and Child's Hospital. The delivery was entirely uneventful. The perineum was lacerated at the time of delivery and repaired immediately. The puerperium was normal. She was in the hospital for twelve days. She felt fine and had no bladder symptoms. The abdominal wall was firm. The perineum practically intact; the cervix was very slightly lacerated and pointed forward. The uterus was retroflexed, small, replaceable, but immediately dropped back into its original position. Evidently a congenital retroflexion.

SUMMARY

The points of interest brought out in this case are the following:

1. The importance and wisdom of preliminary catheterization before an initial pelvic examination.

2. The recognition of distention of the bladder and its differentiation from uterine enlargement by the abrupt convexity of the abdominal wall above the symphysis.

3. The reposition of the incarcerated pregnant uterus by operative procedure, without interference with the continuance of the pregnancy.

4. The resumption of normal bladder function.

5. The normal delivery of a healthy child at term.

6. The resumption of the retroverted position of the uterus after the birth of the child.

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