

Clinical Lecture ON PROLAPSUS UTERI AND ITS TREATMENT.

Delivered at University College Hospital,

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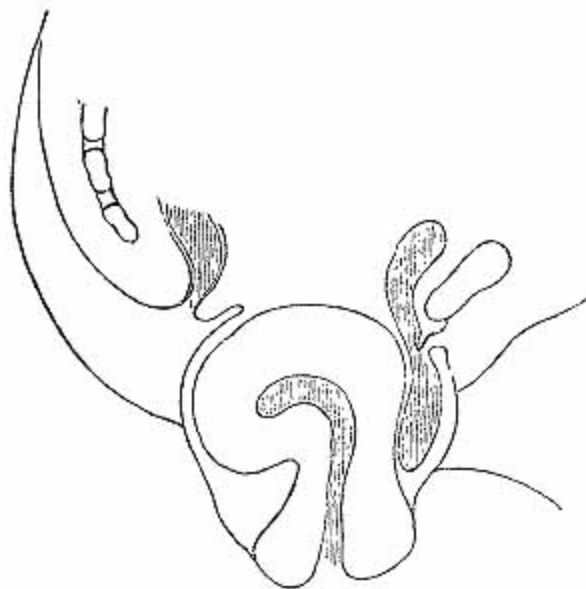
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GENTLEMEN,—I propose to speak to-day of prolapse of the uterus. The subject is an extensive one, and it is one concerning which it is very important that, both as regards pathology and treatment, you should possess definite and reliable principles. Some years ago, every case in which there was a substance protruding from the vulva was considered to be a case of prolapsus uteri. As science advanced, knowledge became more discriminating, and we now know that various conditions are present in such cases. Sometimes it is a portion of the bladder only which protrudes, sometimes the uterus, and sometimes the posterior part of the vagina; not to speak of instances in which the substance protruding consists of something further than this, such as a polypus connected with the os uteri.

A case now under treatment in the hospital will enable us to study the subject in its clinical and practical relations.

Mrs. H—, aged forty-two, has had two children, the last nineteen years before she came under observation. For some years this patient has suffered from one of the forms of prolapsus. The nature of the prolapsus in this case will be understood by reference to this drawing (Fig. 1), which

FIG. 1.

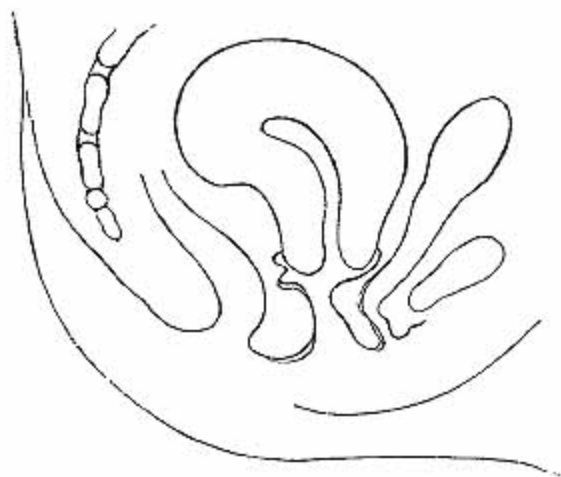


was taken when the patient first came under observation in June, 1868. You will perceive that the whole uterus is outside the vulva, and that the organ is considerably hypertrophied, measuring some three or four times the normal size of the uterus. Further, you will perceive that there is another condition of the uterus which is interesting and important—namely, the retroflexion of the organ. The uterus is not only displaced to such an extent that it is quite outside the vulva, but it is also markedly retroflexed. These points were made out at the time of the examination by the use of the finger only, and they were confirmed by the use of the sound, by which the direction and length of the canal were ascertained. The bladder also is seen to be displaced. Attached to the uterus as it is naturally, the bladder shares in the movements of that organ, and is thus drawn downwards and protrudes at the vulva. The tumour

thus formed, larger than the fist in size, presented a somewhat smooth appearance, and was quite dry, the dryness, of course, resulting from the long exposure of the mucous membrane to the atmosphere. A further condition to which I may call your attention is the enormous distension of the vagina in this case. The vagina under these circumstances is necessarily inverted, and it is distended to an extent corresponding with the size of the uterus. The patient informed me that she could push the tumour back, although only with considerable difficulty; but the moment she assumed the erect posture the tumour came down again. Defecation was attended also with a protrusion of the tumour and very considerable pain. I need not say that the condition of the patient was most distressing: locomotion was painful to her, and she was prevented from doing many things which her condition in other respects would have perfectly permitted.

Let us consider for a moment how it was that this state of affairs came about. I believe that this form of prolapse of the uterus is, as a rule, consequent upon laceration of the vulva at the posterior commissure. The support which should be rendered by the perineum is taken away, and there occurs a descent of the uterus in the pelvis to a slight extent. I believe that in this instance the first event was retroversion of the uterus, followed by a slight descent of the uterus in the pelvis. Here is a drawing (Fig. 2) which

FIG. 2.



represents this, the first, stage of this condition. It will be perceived that the point which first gives way, which first descends in the pelvis, is the cul-de-sac behind the cervix uteri—in other words, the top of the vagina. It falls lower in the pelvis than it was before, and comes down in consequence of the uterus pressing upon that point. In a further stage of this condition, on making an examination with the finger, you will find the os uteri close to the vulva, the cul-de-sac behind the os uteri being quite low down. Still later, the uterus falls altogether outside the vulva, and under such circumstances it falls in a state of retroflexion.

To sum up, then, I believe that in such a case as the one before us the laceration of the perineum is the starting-point; that the uterus then begins to descend, and it descends at the same time that it becomes retroverted; and in an extreme case the uterus falls altogether outside the vulva.

In the next place, I desire to call your attention to the principles which should guide us in the management of cases of this kind—cases of pure prolapse of the uterus, accompanied, as they generally are, by a tendency to retroversion.

The treatment of these cases has been conducted in various methods at different times. Formerly the practice consisted in introducing a large globular pessary, the size of which was adapted to the case. The globe of wood, or metal, or some other convenient material, was placed in the vagina, and was kept there by the contraction of the sphincter vaginae. It thus retained the uterus in its place, and at all events prevented the prolapsus. A variety of other inventions have been used at different times since the globular pessary. Some of them have carried out the principle to which I am about to call your attention, and which I consider so valuable; others have egregiously failed in carry-

ing out that principle. The principle to which I allude is the maintenance of the upper part of the vagina in its proper position in the pelvis. An attentive consideration of the facts relating to the fixation of the uterus in the pelvis leads us to the conclusion that if the posterior cul-de-sac of the vagina be kept in its proper position in the pelvis, it is almost impossible for any considerable displacement of the uterus to occur. This is the most movable point, and it is the point which does become moved in the beginning of prolapsus; and if you can succeed in keeping this part of the vagina in its proper position in the pelvis, you cure the disorder.

The method which I have found most convenient in carrying out this principle is the application of an oval ring, which is adapted, as regards its length, to the length of the vagina, and, as regards its width, to the width of the vagina; and which is kept in its place by being made of a sufficient width below to prevent its escape from the vulvar aperture. When these conditions are complied with, the difficulties of the case are at an end. These instruments we employ largely in the out-patients' room in the treatment of retroflexion; they somewhat resemble in form Hodge's pessary, but the material of which they are made—copper wire and gutta percha—allows of a ready and perfect adaptation of the instrument to the particular case.

In attempting to apply these principles of treatment, we meet with difficulties in certain instances. The most remarkable example of this difficulty is afforded by such cases as that described at the commencement of this lecture—where the vagina is enormously dilated—where the perineum is deficient in its floor, and the uterus completely prolapsed. In such a case as this the application of the oval ring pessary is hardly likely to be attended with beneficial results. And why so? Because the vagina has become so excessively dilated by the long existence of the disease, has become so much hypertrophied by the continual friction to which the parts have been subjected, and the condition of the parts is so very different from that which they present naturally, that we could hope very little from the use of the ring pessary. It would be necessary to employ a very large one in order that it might be retained *in situ* at all, and the use of a very large ring would only perpetuate the distension of the vagina. Nothing, in fact, short of an operation would be likely to give a satisfactory result in such a case as this.

We come, then, to the consideration of the question—what operation? An operation has been frequently practised for the relief of such cases, consisting in a sewing up—for it is nothing less—of the aperture of the vulva so as to reduce it to its natural dimensions. The operation is known as the operation for ruptured perineum, and it consists in laying bare the surfaces on each side and bringing them together. You will perceive, however, how much the operation fails to accomplish the objects which we should have before us in the treatment of such cases as the present one. It is necessary to do something more than merely constrict the aperture of the vulva. Dr. Marion Sims, who is well known for his very great success in reference to operations and mechanical devices for the treatment of uterine disorders, has employed a method which he strongly recommends in the treatment of these cases. Dr. Marion Sims removes a piece of mucous membrane on either side of the anterior part of the vagina. These raw surfaces are brought together by sutures, so that the canal is diminished to the extent of the width of the anterior wall of the vagina. In this way the capacity of the vagina is greatly diminished. This operation has been found to succeed very well in reducing the size of the vagina, and in preventing the recurrence of the prolapse under those circumstances. It occurred

FIG. 3.



to me, in connexion with this case, that another method of operation would be more useful. Desiring, equally with Dr. Sims, to diminish the size of the vaginal canal, which was in this instance dilated to a very great extent, I operated upon the posterior wall of the vagina instead of the anterior. By means of incisions running parallel to the length of the vagina (Fig. 3) I removed a large oval strip of mucous membrane on each side. The edges of these raw surfaces were then brought together by a continuous wire suture. Thus the vaginal canal has been

diminished to the extent represented in the respective widths of these two raw surfaces. The excess as regards the mucous membrane of the vagina presented itself chiefly at the posterior part, and this was my motive for thus operating. The continuous suture brought the edges of the wound very closely and nicely together. I do not imagine that this operation which has been performed on this patient will be sufficient. I contemplate the performance of another, an operation consisting in a diminution of the aperture of the vulva itself, as soon as the patient is sufficiently recovered from the effects of the first operation. Further—and the omission of this part of the treatment has frequently led to disappointment in the results of “perineal” operations,—it will be necessary to improve the condition of the uterus itself, and to restore the organ to its proper shape. The frequent use of the uterine sound will enable us to do something in this direction. A further step in the treatment of this case, which, however, will not be adopted till the patient is sent away, and allowed to resume her ordinary avocations, will consist in placing an oval ring pessary in the vagina, with the view of keeping the upper part of the vagina in its proper place.* You will see that at the moment when the patient presented herself it was impossible to carry out the principle upon which I have laid particular stress, in consequence of the difficulty in keeping the upper part of the vagina in its proper place. The operations which have been performed and which are contemplated will have, if successful, the effect of enabling us to carry out that principle, and there is no doubt that when the uterus has been kept in its place for some months by the aid of a pessary, such as that which I have described to you, the patient will be completely cured.

I do not know that the removal of the mucous membrane from the posterior part of the vagina is likely to be, in all cases, preferable to its removal from the anterior part, which is the plan adopted by Dr. Marion Sims; but, looking at the circumstances of the case, I suspect that the method which was here employed would be likely to be equally useful in other cases also.