

TREATMENT OF UTERINE DISPLACEMENTS

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THE different varieties of uterine displacements and the symptoms caused by them having been fully described by the previous speakers, it now remains for us to consider what means are at our disposal of alleviating or curing these conditions. First of all, do all cases of displacements met with in the course of one's practice require attention? This question may be replied to by a most emphatic negative. One not infrequently finds, while making a routine examination of a patient, that her uterus is in a position of extreme retrodisplacement, and yet feels convinced that her symptoms are not in any way due to this condition; but the physician must be quite sure of his premises before deciding this important point.

Given a patient with a displaced uterus which is causing her trouble, however, what are we to do for her? Are we to rush her into the operating room, and, by some brilliant method of surgery, attempt to restore the woman to health, or are we to endeavour to attain the same object by some slower, but safer, procedure? The answer will depend altogether upon the nature of the case and the circumstances and surroundings of the patient. Women who come under our care in the wards of a public hospital seldom have the time to spare from their household duties to permit of their taking a long rest in bed, together with a protracted course of massage and local treatment of the pelvic organs, and, therefore, they require more drastic handling than their more fortunate sisters, but the knife should always be held in the background until all other means of help have been carefully considered.

Anterior displacements of the fundus are rarely sufficiently marked to cause symptoms, other than that form of dysmenorrhœa beginning a few hours before the appearance of the flow and ceas-

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ing, or at all events becoming greatly lessened, after the flow has once been fairly established. This class of displacement will almost invariably yield most satisfactory results to a thorough dilatation of the cervical canal and curettage, followed by the stitching in place of a tube inserted into that passage and left there for from twelve to fourteen days, by which time the slight lacerations which have been caused in the muscles of the sphincter at the internal os will have been pretty well healed. The procedure removes any diseased mucous membrane which may be present and straightens the uterine canal, thus allowing of much better drainage than existed previous to this manipulation. The first menstruation succeeding the operation is apt to be painful, of which fact the patient should be warned, but the future periods will usually be free and painless for some years to come, and even for all time if the patient becomes pregnant and gives birth to a full term child.

Very occasionally, the ante flexed uterus will be found to press upon the bladder, causing irritability of that viscus. Here the efforts of the physician should be directed towards improving the various muscular structures which hold the uterus in its usual position. This may be effected by the exhibition of tonics, such as iron, arsenic, strychnine, etc., together with general massage, Swedish movements, and local treatment by electricity, tampons, douching, etc. The application of a well-fitting cradle pessary is at times found useful, sometimes allowing pregnancy to occur, which may be followed by cure, owing to the changes produced during involution. However, now and then, cases which resist these milder measures are met with, and then the only really sure and effective method of treatment is either to shorten the anterior vaginal wall, thus causing the cervix to be drawn forwards and the fundus to be lifted off the bladder, or else to open the abdomen and attach the fundus to the anterior abdominal wall at such a level that the possibility of vesical pressure is prevented.

We now come to the next variety, where there is posterior displacement of the fundus, and, as this is rarely uncomplicated by prolapse, retrodisplacements and prolapsus will be considered together. Where the fundus is turned posteriorly, one's first efforts should be directed towards its replacement by methods which are too familiar to those present to require any description here. When one has been successful in restoring the uterus to its natural position and the perineum and vaginal walls are not too relaxed to afford proper support, much relief may be experienced

after the insertion of a properly fitting pessary, preferably a Hodge. In cases which are of comparatively recent occurrence, say within eighteen months, this may in time effect a cure, especially if pregnancy supervenes, involution aiding in restoring the uterine supports to their normal condition. While fixity of the uterus or any inflammatory condition of the adnexa or vagina contra-indicates this method of treatment, pregnancy does not at all preclude it. You may even frequently prevent a threatened abortion in the earlier months by carefully replacing the uterus, inserting a pessary, keeping the patient in a condition of absolute rest, and administering sedatives.

Where the patient has a moderate degree of prolapse with but very slight retrodisplacement, much benefit will result from rest in the recumbent position for several hours each day, combined with local pelvic treatment, by the application of iodine to the vaginal fornices and the use of tampons saturated with some astringent solution, such as the glycerine of tannic acid. This, persevered in for some months, will give many patients, especially older women, considerable relief.

What are we to do for long standing cases of retrodisplacement, and especially those complicated with laceration of the perineum? Here the only method of cure is by operation. This is no occasion to open up a discussion on what supports the uterus, whether it is entirely supported from below or from above, or both, so that we shall take it as granted that the uterus is not only held in place by its several ligaments but that it also receives support from the various structures forming the floor of the pelvis, and that the intra-abdominal pressure aids in keeping it in its normal position of slight ante flexion. In those cases of retrodeviation with slight prolapse, some operation on the uterine ligaments or the attachment of the fundus to the anterior abdominal wall will suffice.

In the vast proportion of examples of this condition with which one meets, there will be more or less congestion or chronic inflammation of the parts, so that one's first efforts should be directed towards its amelioration or cure before proceeding to operate. The importance of this fact is frequently overlooked, and this accounts for a certain percentage of symptomatic failures after operation.

Let us now consider the operative treatment of retrodisplacements which are uncomplicated by any loss of perineal support. There are three routes by which one may operate for this condition; namely, per vaginam, through the anterior abdominal wall, or subcutaneously, and each has its adherents and opponents.

The subcutaneous is the old-fashioned method of cutting down upon and shortening the round ligaments at the external inguinal ring, after the method of Alexander and Adams, or some modification of the same. The great advantage of this operation is the fact that the peritoneal cavity is not invaded, while the two great disadvantages are, first, that the ligaments on which you rely for support of the uterus are structures which are already weakened, thus necessitating the wearing of a pessary for several months after operation to hold the uterus in position while the ligaments are regaining their tone; and secondly, the impossibility of inspecting the condition of the pelvis contents. The preservation of the inviolability of the peritoneal cavity was formerly a great gain, but with the improved surgical technic this argument has lost much of its force.

By the vaginal route, either the round or utero-sacral ligaments may be shortened or vaginal fixation done. In both cases the abdominal cavity is opened so that the adnexa can be directly palpated, or even inspected visually; but this method has no advantage over an incision through the anterior abdominal wall, other than the lessened risk of a post-operative hernia where a vaginal colpotomy is done, though, with careful suturing and the healing by first intention which one ought always to obtain in these cases, there is but little chance of this sequela occurring. It may also be urged that the patient does not require to remain in bed as long after operations by the vaginal route as where the peritoneal cavity is opened from above, but the few extra days' rest necessitated by the latter will give the parts just so much longer time in which to regain their normal condition.

When the peritoneal cavity is opened from above, the operator has the choice of attachment or shortening of the round ligaments or ventro-suspension or fixation. Of the two operations in which the round ligaments are involved, the method followed by Gillian is decidedly the best, and, lest this method is unfamiliar to all of those present, perhaps it will be well to describe it briefly. After opening the abdomen in the usual manner, the anterior sheath of the rectus is dissected off from the muscle as far as its outer border. A pair of sharp-pointed forceps is thrust through the fascia and peritoneum at this point, and a loop of the round ligament seized and drawn through the opening and over the rectus to the middle line. A similar procedure is carried out on the opposite side. The fundus is thus closely approximated to the peritoneum of the anterior wall and held in that position until the incision in

the peritoneum is closed by suture, after which they are fastened together by interrupted catgut sutures and the rest of the incision closed. Care should be taken in this, as in all other abdominal attachments of the uterus, to fasten that organ at such a level that there will be no injurious pressure exerted on the bladder.

Ventro-suspension and ventro-fixation are two separate and distinct operations, each having its own indications, and they should never be confused. Both involve the attachment of the fundus to the anterior abdominal wall. In both, the sutures should be passed through the tip of the fundus to the extent of about half an inch in length transversely and one-quarter of an inch in depth, the anterior suture running along a line joining the uterine extremities of the round ligaments and the second just sufficiently far behind it to provide that punctures, made by the forceps which have been employed to hold the uterus in place during the passage of the sutures, will be covered by the peritoneum of the anterior abdominal wall, thus lessening any danger of the formation of adhesions between the bowel and fundus. In the case of the fixation, the sutures are passed through the peritoneum and any fascia which may be found posterior to the rectus, the fundus being permanently held close up to the anterior abdominal wall; whereas, if one wishes simply a suspension of the uterus, the fascia is carefully avoided. In either case, however, it will be well to include the urachus in the sutures, as this only adds to the strength of the ligament formed. In the suspension, a false ligament develops which allows of considerable free play of the uterus in the pelvis, and yet holds it sufficiently firm to prevent its return to its previous malposition. Of the two, suspension should be done in all cases in which there is the slightest chance of the patient becoming pregnant, the fixation being reserved for those patients who have already passed the menopause or who, for any reason, you have had to sterilize.

Of course, occasionally, some post-operative inflammatory process will convert a suspension into a fixation, but that will rarely happen if one is careful in one's technic and the manner in which one handles the uterus. As regards after effects, the fixation is the more permanent, as you would suppose, but a relapse of the uterus to its old position is rare if the patient has a fair chance to take care of herself for some months after leaving hospital. Pregnancy should be avoided for one year after operation, but even where this does take place within the specified time, in the majority of cases the uterus will be found well to

the front after delivery. Notwithstanding the argument of those opposed to this operation, that it interferes with subsequent pregnancies, this has not been the experience of the writer. Where the suspension has become a fixation, or where the sutures have been passed well down the posterior surface of the uterus, one would expect to have abortion, premature labour, or dystocia, and the expectation is sometimes fulfilled, but that is not the fault of the operation, but of the operator.

Unfortunately, I have not been able to collect sufficiently exact statistics of my own cases for them to be of any value, but, in those which I have been able to follow, dystocia or premature labour has been vastly the exception, and recurrence of the malposition after delivery has been rare.

We must turn now to patients who have posterior displacement complicated with a greater or less degree of prolapse. Here it is absolutely necessary to do some sort of plastic work upon the vagina in addition to one of the above mentioned operations, if lasting benefit is to be expected, the nature of this plastic work depending upon the lesion in the pelvic floor and the individuality of the operator.

Where one has procidentia in a woman past the menopause or who has been sterilized for any reason, complete vaginal hysterectomy with a double colporrhaphy will be found to give the best results. This is certainly a radical procedure, but in these women the uterus is a useless organ, the operation is no more dangerous in the hands of an expert than plastic vaginal work added to the necessary abdominal operation, and the results, both immediate and remote, are excellent.

One more point and I will close. Should a woman with a displaced uterus which is giving rise to symptoms be subjected to operation for this condition? If it is going to give her any relief, most emphatically, "Yes." Against this, it is argued by many physicians, that the next delivery will tear the vaginal wall again as badly as it was before. Granted the possibility, but is there to be a next pregnancy? No one can be sure, and, if there is, and the vagina does tear, the physician can immediately repair it, restoring the parts to their original condition. There is no reason why the woman should not have relief from that dragging sensation or pain in the back, from which so many of these sufferers complain, in between their pregnancies. I know that this suggestion will receive some opposition, but to my mind I fail to see how any man who has seen the woman dragging herself through her dreary day's

toil before the uterine supports have been repaired and again seen that same woman going about her work with comparative, if not absolute, freedom from these manifestations, can be of two minds upon the question.