barrister and the judge have their "long vacation". Even the shop-keepers have their bank-holidays.

But there are other classes—and among them are medical men—to whom no change of seasons nor returning festivals bring, of necessity, holidays for rest and enjoyment. Sunday and Saturday, Christmas and Easter, in winter's sleet and snow as in summer's sultry heat, their work must be done; the guardians of the public health are never expected to desert their posts. Yet no class of professional men better deserve, or more hardly earn, the breathing-time and rest of a yearly holiday. I know that there are some who are willing enough to allow that country practitioners must work hard, but who are inclined to question whether the fatigue of body and mind undergone by the town physician or surgeon is equal to that incidental to the labours of barristers, newspaper editors, and other professional men. But they who think thus reason from mere outward appearances. They see the physician or surgeon rattling along in a brougham; a pile of new literature in the carriage-basket to amuse him as he is whirled from patient to patient; and they are tempted to ask, Where is the great tear and wear of medical life? But they quite overlook the fact that with him, as with every medical man, the chief calls which are made upon his strength are those of an intellectual nature. They forget the constant excitement of his life, the never-ending nature of his work, and the continual worry and responsibility which beset him night and day. They think not of the harassing anxiety which racks his brain, especially when critical cases are under his treatment; or when some valuable life, on which the worldly prospects of helpless wife and children are solely dependent, is prayerfully confided to his care, and tearful relatives look imploringly to him to rescue the loved one from the dark valley.

Does not such a life as this call for the rest of an annual holiday? Think how many men have died at their posts—worked to death—and be warned in time. Think, on the other hand, of that brave old veteran Sir Henry Holland, who all his life long never missed taking his autumnal holiday, and who managed, even after his sixtieth year, to travel, in these annual vacations, over nearly all the world. Be sure of this: that nothing pays better, in the long run, than the little expense involved in obtaining an annual holiday. May I, therefore, hope that, before many weeks, all who now hear me may be able to enjoy a well earned respite from labour and care; and that, among the mountains of Scotland or Switzerland, or by the shores of the sea, or in some pleasant sylvan nooks, they may forget for a time all their professional troubles, and drink in fresh health and strength for the labours of the coming year?

ON THE TREATMENT OF SPECIAL FORMS OF UTERINE FLEXION NOT REMEDIABLE BY ORDINARY MEASURES.*

By C. H. F. ROUTH, M.D.Lond.,

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I DO not propose, in this communication, to discuss in its entirety the subject of uterine flexions. I have already done so fully in two papers: one on Uterine Deviations, published in the *Medical Press and Circular*; the other on the Use of Intra-uterine Stems in Uterine Disease, published in the fifteenth volume of the *Obstetrical Transactions of London*. I desire to speak of those complete forms of flexion which occasionally occur, and which resist ordinary modes of treatment.

I have fully discussed, in the first paper referred to, the etiology of these cases and the preliminary treatment called for. What ligaments are especially affected; the influence of a top-heavy organ, from whatever cause produced; the extension of endometritis to the parenchyma of the organ; the effect of adhesions or an accident in determining a flexion—all these points I have fully discussed; but I wish to speak of those cases where the flexion is so complete that the ordinary treatment is useless, and those where even intrauterine pessaries are of no avail.

First, there are cases where the upper part of the uterus or the fundus seems to move upon the body or cervix very much like upon a ball-and-socket joint; i.e., there is so much weight superiorly, and so much want of tone at the point of union with the fundus and body or body and cervix, that all support at this point is wanting, and the fundus uteri, always unusually heavy and large in these cases, topples over in the direction in which the woman's body is turned. I have

purposely said body or cervix, because it is not always easy to determine where the point of flexion begins and ends. In some, it has appeared to me much lower than in others; nor can it be made out accurately by finger or sound. I suppose every practitioner who has had much to do with flexions is aware of the fact that he has sometimes examined a case attentively, has found well-marked retroflexion, and has noted it in his notebook, and has seen the case in a few days, and has found equally well marked antelexion. Possibly, at first, he may have been led to believe he was not sufficiently careful in his first examination; or possibly he may find himself in direct opposition with the opinion of some other practitioner, who has found the opposite condition present to that which he has described. The progress of the case, however, will soon clear up the diagnosis, and the recurrence of other similar cases will prepare him for the occurrence of such contingencies. But delay is by no means necessary to prove the condition. It suffices to place a woman first on her back, with the buttocks raised, and retroflexion will be induced; and then on all fours, and antelexion will occur. In the same way, lateral version may be produced by placing the woman on either side. The diagnosis can, therefore, always be made on the spot, and thus all differences between the practitioners explained.

This variety I would venture to call a ball-and-socket version, by way of distinction.

But, secondly, there is another variety, in which either retroflexion or antelexion takes place, not at the union of body and cervix, or of fundus and body, but at the union of the vagina and uterus. I will best illustrate my meaning by a case.

The late Mr. Baker Brown during his last illness sent a young lady to me, the wife of an officer of rank. A beautiful creature, and most active and energetic at other times, during the period she became seriously ill. While it was pending, she became at times almost maniacal—at any rate, extremely violent, inflicting sometimes corporal punishment on her husband, and quarrelling with him in a frantic manner. She suffered intense headache, local uterine pain with dragging sensations, and backache. As the more violent head-symptoms subsided, she became exceedingly low-spirited and wretched. The bearing-down pain was greatest during defæcation. A few drops of a kind of show made their appearance, followed for a day or two with molimen; and then the symptoms entirely disappeared, and she once more became the beautiful and fascinating woman. Her husband informed me that, excepting at these times, she was of a very warm nature—at times almost nymphomaniacal. Her great desire was to have a child. An examination of the parts revealed an extraordinary state of things. The vagina was unduly short. The os could be felt with difficulty immediately behind the vagina; and lying parallel with the vagina lay the uterus, rather larger as to volume. Having reduced it with some difficulty, I found the cavity not exceeding two inches. The pelvis was unusually capacious, and, once the organ reduced, it could be moved with the sound in any direction and with the greatest ease. There was, however, one curious point in this case. There appeared to be no cervix within the vagina properly so called, and no posterior or anterior *cul-de-sac*. The os, which was very small, was to be seen and felt; and the cervix, rather narrow, could be felt also behind the vagina; but both were on the same level as the upper part of the vagina.

In the treatment of this case, my first care was to reduce all local congestion by leeching, purgation, etc. I next opened the os carefully with the hysterotome, taking care not to cut beyond the cervix, which was, as I said before, unusually narrow, and thus wound the peritoneum; and, by the subsequent application of sea-tangles, I at last got the canal sufficiently patent to admit an intra-uterine pessary, which was well borne and gave no pain.

Imagine my surprise the next day to find the uterus in its old position behind the vagina, although the stem was retained within it. My patient was, moreover, much dissatisfied. The discomfort was even greater, and, after all the torture to which I had put her, she was positively worse than before. The reduction of the uterus to its normal position gave immediate relief and restored her good nature; but it was only temporary after all; any exertion, or a walk, had the effect of making it fall back again, and reproducing all the disagreeable symptoms. While the stem was within the uterus, however, we noticed some advantages. There was very much less pain during the periods; the cerebral excitement did not always recur; the uterus was certainly lighter; the bearing-down pains were only experienced occasionally during defæcation; and the quantity of catamenia and molimen subsequently was greater.

I now devised a new instrument. To the front part of an ebonite Hodge's pessary I affixed an intra-uterine pessary, which, by a peculiar arrangement, was provided with an elastic India-rubber spring, so that the stem was pushed forward. In this manner I hoped to overcome the

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tendency to retroflexion. The great disadvantage I found here was the absence of a vaginal posterior *cul-de-sac*; and this defect obliged me to place the stem far behind, and two or three instruments had to be made before I could get one to remain in position. The first two turned clean over. The uterus fell back at right angles with the vagina, or a little more, with the stem within it; and the Hodge portion of the instrument was turned upwards, pressing against the anterior wall of the vagina; and this change in position was always induced by any exertion or by walking. At last, with Messrs. Krohne and Sesemann's assistance, I devised an instrument which seemed to remain in; and her husband wrote me some time afterwards to the effect that the instrument continued in place, and that the catamenia were as they should be, though there was a continual discharge slightly coloured. He was anxious to have the instrument removed. I saw her again some time afterwards, but found that, with the removal of the instrument, the uterus in a very few days fell back, and I had to replace the instrument.

I think it was in 1874 that she removed to the sister island, and I confided her there to the care of Dr. More Madden. He described to me in a letter her condition. "I saw Mrs. — for the first time yesterday, as she had been complaining of some uterine discomfort, evidently the result of some displacement caused by the long and severe jolting she had in the journey from London. On examination, I found the exact state of things you describe; the uterus small, and marked absence of cervix; the stem still fairly within the uterus; yet the fundus had again fallen backwards, the os to the pubis; the pessary being, of course, displaced. I pushed the fundus upwards, and by a little traction at the same time with very little difficulty brought the pessary as nearly as possible into its proper position."

In a case like this, of what possible avail could any Hodge's pessary whatsoever, or internal stem, singly, be in the way of cure?

Precisely analogous cases have occurred to me, only in these instances they were examples of antelexion; and these cases, perhaps, are more common. The flexion is mainly at the cervix; and the tendency is to lie also in a parallel direction to the vagina, with the os looking backwards, only that the flexion cannot be so complete, because of the intervening bladder. These cases are invariably sterile; the position of the cervix leading always to an accumulation of acid vaginal mucus at the upper portion, and necessary destruction of all spermatozoa.

It is manifest that, to remedy these cases, two things are necessary. We must keep the uterus high up, so as to prevent its having the power to make, as it were, the somersault; and, secondly, when so retained, keep it from this tendency by an internal pessary. This can only be done by a Hodge's and internal pessary combined. And, thirdly, endeavour to keep the vaginal portion of the cervix, in cases of retroversion, more near the sacrum, and, in cases of anteversion, nearer the pubes, so as to militate in both cases against the tendency to be pushed further from these two points respectively, and so giving a *point d'appui* to the fundus against neighbouring parts. In cases of ball-and-socket flexions, as I have called them, the object can only be to keep the parts in their normal position in the axis of the pelvis.

I suppose everything has been done in such a case in the way of antiphlogistics. The congestion has been reduced by all known appliances: blistering, purgatives, local bleeding. Ergot and small doses of mercury have been given internally, with, perhaps, Kreuznach and Woodhall Spa water. We have now to apply the mechanical part of the treatment.

A ball-and-socket case can be well treated by one of Simpson's much condemned pessaries, similar to that which I now show you. Once applied, it can be retained, if it fit well, with anything but discomfort. The objections to its use are mainly two. In the case of a married woman, it effectually prevents all conjugal relations; and it is apt to give rise to a good deal of inflammatory action.

1. However well it behoves us, as medical men, to advise in theory moral restraint in such cases, and a temporary suspension of sexual relations, in practice I have found it a source of much family trouble. Wives have often complained to me of a resulting coldness, if not unkindness, on the part of their husbands; and I know it has often been the cause of infidelity on the part of the man. Even so great a Stoic as St. Paul admitted this. He, who began by saying, "Defraud ye not one the other, except it be with consent for a time, that ye may give up yourselves to fasting and prayer", also felt bound to add, "And come together again, that Satan tempt you not for your incontinency". (1 Cor., vii, 5.) Unfortunately, Simpson's instrument effectually prevents this; and the temptation often occurs as a consequence, for, to do good, it must be kept in a good year.

2. It is often said to produce a good deal of neuralgia, to keep the uterus too much in one position, and, by not admitting any movement of the uterus from side to side, to give rise to cellulitis or catarrh of

the uterus. These effects, indeed, have so often followed the use of the instrument, that it has got a bad name and is now almost invariably condemned. Yet these last defects are in great measure remediable. A ball-and-socket joint may be placed superiorly, admitting a certain amount of movement on either side; and a moderate amount of cellulitis, if kept within bounds, is not always so injurious, as it becomes curative in the end, keeping the uterus in position.

But whatever objections may apply to Simpson's instrument I do not think hold good in regard to the instruments I now show you, and which I have devised to meet these cases. I now show you three kinds, prepared by Mr. Russell, of 37, George Street, Portman Square, to which I was gradually brought by seeing the excellent effect produced in one of these cases by a similar but less perfect instrument I devised years ago (1874) and worn by the patient to this day, and by observation of the good done by Dr. Wynn Williams's instrument, which I also show you. It consists, you see, of an internal stem, which is first introduced into the uterus by a stilette. Once fixed, the support, which, you perceive, is an India-rubber disc with large holes in it to allow of free egress of all discharges, and a central pouch into which the distal end of the intra-uterine pessary is fixed, and so the stem is kept in position; whereas, the support being all of India-rubber, a ball-and-socket movement of the stem is allowed to occur, and thus the jerks of Simpson's instrument do not occur. I must admit that, once applied, this instrument acts beautifully and effectively, especially in cases of antelexion. I am also bound to add that several cases of antelexion so treated have recovered perfectly, and the women, being formerly sterile, have ended by becoming mothers of families. I have but one objection to the instrument, and even this objection is in great measure modified by Dr. Wynn Williams's later improvements in its manufacture. My objection is, that it leads to the accumulation of foetid mucous discharges about it; and this was especially the case when the membrane was fastened to the lower rim of the Hodge skeleton. Now that it is fastened to the upper rim, the accumulations cannot so readily occur, and the odours are not so intense; and I can quite understand that, if women be ordinarily clean and use freely antiseptic injections, they may remain sweet with Dr. Williams's instrument as now devised. The comfort from its use is such that many women who have worn them avoid seeing the doctor again, lest it should be removed; and connexion is not more interfered with when a woman wears this instrument than with an ordinary Hodge's pessary. But it is not every woman who is properly particular, while wearing these instruments, in using injections freely. Besides, it is the nature of India-rubber to acquire a very bad smell in the vagina. Even with one of Dr. Greenhalgh's intra-uterine stems, the part within the vagina becomes after some months, in unclean women, offensive to the last degree. It is not so with ebonite; and, as you see, some of these are exclusively made of this substance.

I now show you the three varieties: one with an India-rubber band; the others exclusively made of ebonite. You will perceive that in all three we have a Hodge's pessary inferiorly.

In the first and cheapest variety, there is an India-rubber flat band placed across, which fits in a groove on each side, and can be moved forward or backward on this. In the centre of this India-rubber band is placed a stem. Its very position allows of a ball-and-socket movement like Dr. Williams's on the India-rubber band; but, while the band is much stronger and flatter, the tendency is to keep the uterus in a straight position, and thus oppose any tendency to flexion, in whatever direction the inclination may be. It cannot accumulate round itself much mucous discharge.

The second variety, all of ebonite, also consists of a Hodge's pessary, to which a cross-piece is affixed. This cross-piece may be shifted forwards or backwards by moving the screw I here show you into one or the other of these holes. The stem is fixed to the centre of the cross-bar, either permanently by a ball-and-socket joint, or it is made of two parts—one a shorter piece, fixed by a ball-and-socket joint to the centre of the cross-piece; and the other a separate piece hollowed out inferiorly, which fits outside this shorter piece.

The third variety differs from the preceding in having affixed to the posterior part of the cross-piece an additional piece, which is double, lengthening or shortening upon itself by a screw. The cross-piece before referred to is now no longer moved forwards or backwards by shifting the position of the screw, but, the ends fitting into a slit in the Hodge's pessary in each side, is capable of being moved forward or backward as we screw or unscrew the additional back-piece.

In applying these instruments, especially the first, there is some difficulty sometimes, especially in very small vaginæ. The longer the vagina is, however, the longer should the Hodge piece be. A stilette is passed through an aperture which will be found at the lower end of the stem-portion; and it is introduced in the direction of the vaginal

slit, through the vulva, and turned, when the stem is within the os uteri and the Hodge portion within the vagina.

In the second and third varieties, the stem is first passed with an ordinary sound within the uterus, and then the Hodge and shorter piece introduced. The shorter piece passes readily within the hollowed stem. In cases where the uterine canal is small, it is best to premise operations by a sea-tangle or sponge-tent.

It is remarkable what comfort these instruments give, when once applied. They have the disadvantage sometimes of provoking a temporary menorrhagia, as all intra-uterine pessaries do; but this can be readily arrested by the proper remedial means. But one effect that I have noticed is the large size to which, after their employment, the external os attains. The end of the index finger may be inserted. The advantage, in cases of sterility, of such a dilatation is at once obvious, for this dilatation becomes to a certain degree permanent. The same result renders the employment of these instruments in cases of dysmenorrhoea equally obvious. Certain it is the dilatation effected by stems without a support, however large, is much less considerable than that which these kind of instruments induce; and the reason is easily understood. In whatever direction the tendency to flexion may be, in exactly the opposite direction has the lower part of the stem a tendency to dilate the os, because this last point is fixed. It will also be seen how, with the third variety of instruments I now show you, a version may be gradually rectified, and therefore more permanently, the tissues conforming thereto by the gradual movement of the automatic screw.

ON PERITONEAL ADHESIONS OF THE GRAVID UTERUS AS A CAUSE OF *POST PARTUM* HÆMORRHAGE.*

By G. DE GORREQUER GRIFFITH, L.R.C.P.,

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UNDER such a head, Dr. Graily Hewitt described a case before the Obstetrical Society, at its meeting held on May 5th, 1869 (see *Obstetrical Transactions*, vol. xi, page 108).

"I wish," he said, "to draw the attention of the Society to the existence of one particular cause of *post partum* hæmorrhage which, so far as I am aware, has escaped the attention of obstetric writers and practitioners: I mean the existence of peritoneal adhesions of the gravid uterus, whereby the organ, after the expulsion of the child, is held and forcibly restrained, entirely or partially preventing that contraction which is so essential to the expulsion of the placenta, and to the prevention of *post partum* hæmorrhage."

Dr. Hewitt thinks that some of the various conditions of the uterus spoken of as causing *post partum* hæmorrhage may have really been the lesion he describes, but that it had been unrecognised because unknown. By these adhesions, the uterus is kept from contracting, and so the "mouths of the uterine sinuses must be held open, and a ready egress afforded to the blood in the maternal system".

I will here give a *résumé* of the *post mortem* appearances of the womb as found in his case, using, as nearly as is consistent with brevity, Dr. Graily Hewitt's own words, while I will also quote *verbatim* some of his remarks.

"The uterus, on being examined, presents a very unusual appearance. The peritoneal surface wants the smoothness usually observed. It is covered by bands and strings of a tough consistence and fibrinous appearance. The bands are reticulated. The ends of many of these strings are quite free, as if they had been attached to some fixed point and had been broken away from it. These strings or bands are found most numerous on the posterior aspect of the uterus; some of them are three inches long, and, when immersed in water, they give a shaggy appearance to that surface of the uterus. It is certain that these bands connected the uterus firmly with the abdominal parietes or with the viscera up to the time when labour occurred; and that, when the uterus descended, they were first much stretched and finally broken across. The uterus was nine inches long; its walls three-quarters of an inch thick. Examination of the interior of the uterus showed the attachment of the placenta had been to the posterior wall, and here the surface was granular, minute clots filling the aperture of the uterine sinuses, and projecting from these cavities a quarter of an inch or more into the interior of the organ. The sinuses of the uterus in the vicinity were large but empty."

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"Some further reflections", he continues, "suggest themselves on this interesting case. It has been stated that the uterus was 'apparently' well contracted after expulsion of the child, and before the hæmorrhage came on. Was this correct? I believe that such was the case, and my explanation of the matter is, that the uterus followed up the child, so to speak, and, in so doing, stretched the bands of adhesion so far as to allow of the fundus sinking lower into the abdomen, and to present to the taxis an 'apparently' good contraction. But these adhesions, being too strong to give way, and possessing a certain elasticity, subsequently—that is, in the course of half an hour—pulled back the uterus to the top of the abdomen, where it was afterwards found when the placenta was actually extracted. The re-expansion of the fundus would, of course, lead to hæmorrhage."

"In conclusion", said Dr. Hewitt, "I venture to express the belief that the subject now broached is an important one in its bearing on obstetrical practice. The inferences which follow, as regards the management of the third stage of labour, are of a very obvious nature. To follow down the uterus by the hand after the expulsion of the child; to be satisfied, by actual and close manipulation externally, that the uterine tumour possesses the proper shape, and that it is well down in the abdominal cavity: these points are evidently those to which we should direct our attention, not simply in one case, but under all circumstances. So far as my experience goes, *post partum* hæmorrhage is far more liable to occur where the attention of the practitioner is called away from the mother to the child when asphyxiated, and absorbing all the energies of the attendant for its resuscitation. It is during the few minutes which immediately follow the expulsion of the child that the condition of the uterus is mainly liable to go wrong; and, if there be a hidden pitfall, such as adhesions of the uterus of the kind here described, extraordinary care will then be required to avert hæmorrhage and other evil results. Peritonitis, leading to formation of adhesions, may, it is now shown by the pathological facts presented to the Society, occur during pregnancy, and the pregnancy go on undisturbed by the existence of the inflammation. It appears to me probable that peritonitis is not unfrequent in the pregnant state, and, if so, it will go far to explain those anomalous pains and distressing sensations incidental to pregnancy, which are generally set down to other causes than that of inflammation. Further research will doubtless increase our knowledge on this subject; for the present, I content myself with pointing out the connection of these adhesions with retention of the placenta and consequent *post partum* hæmorrhage."

I am not aware that anyone, except Dr. Graily Hewitt, has drawn attention to the fact that hæmorrhage after the delivery of the child may be occasioned by adhesions, the result of inflammatory action during gestation, such adhesions holding the uterus high up in the abdominal cavity, the fundus being near the diaphragm, and the entire organ unable to contract so efficiently as to check the bleeding that may occur when the after-birth has been removed by the hand of the accoucheur, such removal being necessitated partly by inertia uteri and partly by the action of those adhesions to which in this paper reference is made.

I will give a case in point. Mrs. B., aged 37, came to me from Norfolk to be attended in her confinement. She had on two former occasions been delivered with instruments, and I had previously—about a year before—to terminate her labour by means of the short forceps, owing to delay occasioned by a circular narrowing of the entire pelvis, and the projecting inwards of the tuberosity of the ischium on each side.

In July 1876, she wrote to me, telling me she was again pregnant, and I advised her to have labour induced at once, as there was no time to lose, she being then in the eighth month. Accordingly, she came up to town. Allowing her twenty-four hours to rest after her journey, I proceeded to induce labour by passing the forefinger through the os uteri, sweeping it all round the zone of the entrance to the womb, and thus causing dilatation and some uterine pains. I next passed a male gum-elastic catheter, deprived of its stylet, through the os uteri, between the membranes and the walls of the womb, taking every care not to rupture the amnial sac; and this instrument I supported with a well larded soft pocket-handkerchief introduced into the vagina. I had Dr. Barnes's dilators in readiness; but the pains came on so sharply, and the os opened so rapidly, that there was no occasion to employ them.

All went on well for some time, and I hoped my patient would be delivered naturally; but at length the arrest in the downward progress of the head occurred. She lost patience, though I assured her that, if she would only be patient, all would be terminated without the use of instruments. This I judged from the size of the child's head, and because I felt the advance of the presenting parietal bone. I told her my opinion emphatically, as I was anxious she should have confi-