A CASE OF CHRONIC SENILE INVERSION OF THE UTERUS FOLLOWING THE DEVELOPMENT AND REMOVAL OF A FIBRO-MYOMA: AMPUTATION: RECOVERY.*

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SEEING that the subject of inversion of the uterus was to come before the Obstetric Section, and feeling that the collation of clinical illustrations affords the most useful means for a right understanding of pathological and therapeutical problems, I have been induced to submit the following case.

Two or three preliminary observations I may be pardoned for obtruding. In discussing inversion of the uterus, especially with reference to treatment, it is essential to bear in mind the distinction I have laid down elsewhere between recent and chronic inversion. An inversion may be described as recent, so long as the due involution of the uterus following labour is not completed. This process takes about a month. During its progress, the uterine muscular fibre still retains more or less of the contractility, dilatibility, and vascularity of the pregnant organ. When the process is complete, the muscular wall of the uterus has lost much of the contractility, dilatibility, and vascularity which are developed under pregnancy. Those methods of reduction which are comparatively easy if tried within a month after labour may fail if tried at a later period.

In the case I am about to relate, the inversion was first noticed ten years after the woman's last labour. It was discovered after the removal of a fibro-myoma; and the inversion was probably—not certainly—-independent of the process of labour. Beginning with the classical case of John Hunter, the preparation of which is in the Hunterian Museum, I have collected in my *Obstetric Operations and Diseases of Women* several cases of inversion caused by fibroid tumours. I now describe an interesting case of this kind. Although, in these cases, the growth of a tumour in the uterus may induce muscular development in the proper uterine walls analogous to that observed in pregnancy, still the condition of the uterus, as it comes under observation, much more closely resembles that of chronic inversion. We may, therefore, class the case I now describe as one of chronic inversion. We might, perhaps, even with stricter propriety, refer it to a third order of cases; namely, to one which includes chronic cases observed in women who have reached or passed the climacteric. In these cases, the uterus has gone beyond the involution which follows pregnancy. It has been still further affected by the involution of senility or decrepitude. These, then, may be classed as "senile chronic inversion". The uterine tissue is more dense; the muscular element is disappearing, the fibrous predominating. Hence reduction by taxis or the various manœuvres found effective in the recent and ordinary chronic inversions is more difficult. My present case falls under this order. The woman was near fifty, and senile changes had set in.

In November 1877, I saw, at some distance from London, a woman aged 47, who had had her last child ten years before. Since that time, she had suffered much from metrorrhagia, and this had lately much increased in severity. Being active in business—she was the wife of an innkeeper—she went on disregarding her condition until the losses told so much upon her that she was compelled to give in. She was very stout. I found a large firm mass, rounded, filling the pelvis like a child's head. The hand passed in with some difficulty, surrounded the tumour, and traced its attachment by a broad pedicle to the uterine cavity. I adjusted a wire and cut it through by *écraseur*. A little bleeding followed. The tumour was so large that it was with difficulty brought through the vulva which had previously admitted my hand. It was a fibro-myoma of the size of a small foetal head. She made a good recovery, and resumed active work.

In May 1879, I was summoned to her again. She had again been suffering from menorrhagia, alternating with offensive watery discharges stained with blood. She was very blanched and very prostrate, and had increased in stoutness. I found a pyriform tumour of the size of a Jargonelle pear, with a small pedicle in the vagina; the root quite continuous with the vaginal roof, leaving no passage beyond for the sound. Her condition made it imperative to remove it with the least possible delay. I applied a wire as before, thinking it was a polypus; but, on tightening the wire, the acute pain aroused the suspicion that it was the inverted uterus. This was verified by closer examination. Still we

determined to persevere with ablation, knowing that her condition was too low to bear the tedious, painful, and probably forcible process of reduction by sustained elastic pressure. I therefore deliberately cut through the pedicle with the wire. Rather free bleeding followed; this was staunched by swabbing with tincture of iodine. Considerable pain in the abdomen followed; this was allayed by opiates, and she slowly recovered. My friend Mr. Turrell reported on July 6th that she had progressed favourably—had walked for more than half an hour the day before; and that, examined by the speculum a week before, the cicatrix appeared complete, and all constitutional disturbance had subsided. The temperature rose during the first week to 100.5° and 102°; the pulse to 104, and then fell to normal rate.

The specimen is in the Museum of St. George's Hospital. It is laid open to show the interior. The extremities of the Fallopian tubes and of the round ligaments are drawn into the inverted cavity.

The question arises, When was the inversion produced? It might have arisen before the removal of the tumour in the first operation, or during that operation, or at some subsequent time. Which is the more probable? It is difficult to understand how the uterus could turn itself inside out after the tumour was removed. But it is not impossible that the stump left behind might be so large and projecting as to excite uterine expulsive action, and that thus the inversion was completed soon after the first operation; the stump meanwhile undergoing disintegration and disappearing. But I am more inclined to conclude that the inversion was produced or completed during the operation or immediately after it. I had no opportunity of examining again; and, indeed, she got on so well that there seemed no indication for further treatment, until a year later.

Another question arises: one which I put to myself with especial point, because I acted in opposition to rules upon which I have much insisted. Might not reduction have been effected and amputation avoided? Might not the resistance have yielded to sustained pressure, aided by taxis and the operation I have recommended and practised with success, of incising the neck of the uterus? It is impossible to answer this question in the negative. The attempt, I knew, would be attended by unusual difficulty, suffering, and danger; and, since the subject had reached the climacteric, the loss of organs which had already passed into decline could hardly be regarded in so serious a light as the loss of organs still in the plenitude of functional life. In these cases, then, of senile chronic inversion, the methods of ablation come into stronger competition with the methods of reduction than they ought to be permitted to do in cases of simple chronic inversion. Still I think that even in cases of senile chronic inversion, where the conditions are favourable to the attempt at reduction, the attempt ought to be made. I venture to conclude with the following propositions.

The division of uterine inversions into three orders—namely, 1, recent; 2, simple chronic; 3, senile chronic—it will be seen, is based upon clear physiological distinctions; and this division carries clear therapeutical indications. In the recent cases, immediate reduction by taxis is almost always indicated. In the simple chronic case, taxis, aided or not by sustained elastic pressure and incisions of the uterine neck, is indicated, and will almost always be feasible. In the senile chronic cases, reduction by taxis, aided by every ancillary means, though still indicated, will be much more difficult of execution; and amputation, the last resource, will be less open to physiological objection, and at the same time less dangerous, than in the first two orders of cases. It must finally be borne in mind that, especially in the senile chronic inversions, tolerance may be acquired, and thus render all operative interference unnecessary.

THE TREATMENT OF CHRONIC COMPLETE INVERSION OF THE UTERUS:

WITH CASES ILLUSTRATING THE ADVANTAGES OF THE DIRECT METHOD OF APPLYING ELASTIC PRESSURE.*

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THE time has at length arrived when the treatment of inversion of the uterus can no longer be looked upon as an opprobrium to gynæcology. Now, it must be a very exceptional case which cannot be cured, or which demands for its relief dangerous or mutilating operations.

It will be convenient to consider the present subject under the heads Reposition, Aids to Reposition, and Repositors.

* Read in the Section of Obstetric Medicine at the Annual Meeting of the British Medical Association in Cork, August 1879.

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