A MODIFICATION OF HYSTERORRHAPHY FOR CHRONIC SENILE PROCIDENTIA.¹

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THE practical requirements for successful ventral uterine fixation are—to heal erosions and ulcerations, and reduce the size and weight of the uterus before attempting fixation. So far as practicable, vaginal prolapse must be corrected by astringent douches—for example, oak bark, quebracho, etc. The uterus should be temporarily supported by a pessary; above all, hyperplasia must be corrected by rest in the horizontal position. As a lesser operation, perineorrhaphy, with or without colporrhaphy, may be first tried, especially in cases where rectocele or cystocele is a marked complication. Despite all these measures, a few cases will be found to require something more. Unless a trial of shortening the round ligaments is made, ventral fixation of the uterus is the only radical cure.

For chronic senile procidentia, the following procedure seems to me likely to become more generally used than any hitherto employed:

Operation.—The uterus is well returned within the vagina; then, by means of a broad-pointed sound-like repositr, it is pressed up against the abdominal peritoneum. A short incision is made in the mid-line through the superficial and deep abdominal layers down to, but not through, the peritoneum. A narrow curved needle, with a fairly large eye, of Hagedorn's pattern, and fixed in a long firm handle, is introduced *per vaginam*, and brought out through the right side of the uterus and through the exposed abdominal peritoneum. The needle is threaded with strong silkworm gut or reindeer tendon, or silver wire, from the abdominal side; the needle is withdrawn through the same puncture, the thread is drawn through, and the lower end brought into the vagina. The ends of the suture are fixed with catch forceps. The needle is disinfected, then reintroduced, and made to pass through the left side of the uterus and the abdominal peritoneum covering it; the needle is threaded as before, and, on being withdrawn, brings the left side thread into the vagina. There are now two single threads or two free ends inferiorly, with a loop on the abdominal aspect; the latter should be divided, and the ends fixed with forceps. The forceps on the vaginal ends of the sutures are removed, and on each suture a small, stout flattened ovoid glass disc, with rounded edges, or a plate of decalcified chicken bone is slipped. A little manipulation may be needed to get the discs through the cervix. As a rule this can be managed by steadying the uterus, if need be, by volsellæ, and then guiding the discs sideways by forceps, or by gentle traction on the abdominal ends of the sutures. Before tightening the sutures, care must be observed that the intrauterine repositr maintains the fundus uteri in close apposition to the abdominal peritoneum. The sutures are now drawn tight from the abdominal ends till both discs are closely applied to the inner uterine wall; the operator should be able to lift up the uterus by means of the threads. If the uterus is unduly large, or if there is any doubt about the position or strength of the sutures, a third or fourth disc may be introduced in the manner already described, but this will seldom be necessary. The abdominal ends of the sutures are now threaded in an ordinary Hagedorn's needle, and passed through the muscular layers of the abdomen; discs of bone or glass may be slipped on, and the sutures secured and buried. At times the sutures from the opposite sides are tied together and then buried. The intrauterine repositr is withdrawn. (Two deeply buried silkworm gut stitches, including the whole thickness of the uterine wall, but not passing through the endometrium, may be used to further connect the uterus with the abdominal muscles. These latter stitches are only to be used when the uterus is large and heavy). The abdominal wound is closed. The vaginal ends of the sutures are not cut short, but allowed to remain as drainage tubes for ten days. The vagina is packed with antiseptic tampons for a fortnight. If the sutures

are not loosened by the end of a fortnight, they are cut off at the level of the os. The patient should be kept in bed for three weeks after operation, and, in a considerable proportion of cases, it may be desirable that a pessary should be worn for two or three months after getting up. In event of retro-uterine adhesions, it may be necessary to open the peritoneal cavity and break these down. If this has to be done, a strip of uterine peritoneum should be dissected off by scissors and the uterine surface stitched to the parietal peritoneum, as practised by Caneva, of Milan, and many others.² This should be done after the intrauterine sutures have been passed, but before they are tightened.

The advantages claimed for this operation are—

- (1) It gives more secure and reliable fixture than any other.
- (2) The time occupied in performing the disc operation is much shorter than in plastic methods.
- (3) Sufficient adhesive peritonitis is induced to warrant belief that, after the absorption of sutures (if destructible sutures are employed), the uterus will retain its relations to the abdominal wall.
- (4) The risks of bleeding are *nil*. The risks of septic absorption from the thread passing through the uterus are practically *nil*; fluid matter will come down into the vagina, and the sutures, passing through the substance of the uterus with the closely applied discs, block the uterine end of the suture tract, and prevent passage of fluid into the peritoneal cavity.

(5) The operation is much easier than a plastic method. Any operator conversant with the uterine sound can do all that is needed.

I believe that strands of glass threads might make an excellent and imperishable suture, pliable as silkworm gut, non-irritating, and more durable than silver.

In senile uteri, the small glass discs do no harm; probably they pass out in course of time. In younger women, chicken-bone plates (like Senn's intestinal plates) should perhaps be preferred. They may pass out or become absorbed. The adhesions produced may also become absorbed. But if the uterus is kept well up for a time and the vaginal walls regain tonicity, the procidentia will be found cured, even if time destroys the adhesions and absorbs the sutures.

ON OPERATION FOR FRACTURE EXTENDING INTO JOINTS.

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FRACTURE in the immediate vicinity of and extending into a joint is an injury which must always cause serious anxiety with regard to the future function of the joint, more especially if the fracture is a comminuted one, or if, owing to the occurrence of swelling before the case comes under notice, a satisfactory diagnosis of the exact injury cannot be made. No doubt, in some cases, a fairly satisfactory result is obtained where early passive motion and subsequent massage are employed, but too often the result is considerable and sometimes serious impairment of movement. The question, therefore, arises whether, at the present time, seeing the impunity with which we can open healthy joints under aseptic precautions, we ought not to cut down at once in certain cases of fracture extending into joints with the view of restoring the fragments to their proper position or of removing useless fragments, especially where the fracture is a complex one, or where comminuted fragments are present which cannot be manipulated into position, and which tend to lock the movements of the joint, and interfere permanently with its function. I venture in this paper to bring forward four cases in which, for the reasons above given, I have interfered by operation with, I think, great benefit to the patients. I only speak here of recent cases. Some years ago, in my book on *Antiseptic Surgery*, I mentioned several instances in which joints had been opened in the course of operation for badly united fractures in the neighbourhood of joints, or extending into them, and since that time the number of cases of that kind has considerably increased; nor have I included opera-

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² *Hystéropexie*, par M. Baudoin, pp. 318-370. Paris: 1890.