Remarks

ON

RETROVERSION OF THE UTERUS.

A PAPER READ BEFORE THE HAMPSTEAD DIVISION
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BY

WILLIAM J. GOW, M.D., F.R.C.P.,

OBSTETRIC SURGEON TO OUT-PATIENTS, ST. MARY'S HOSPITAL,
LONDON.

BACKWARD displacement of the uterus is very common and much has been said and written about it, but, none the less, the condition often presents a problem of considerable difficulty to the careful practitioner. For the sake of convenience, the term "retroversion" will in this paper be used to include cases where retroflexion also exists. This condition is by no means so simple as at first might appear.

Quite apart from the degree of retroversion, there are undoubtedly various kinds of retroversion. How to describe these varieties is by no means easy. For example, it is no uncommon thing to find the uterus to be retroverted one day and anteverted the next. The backward position in this case seems to depend on occasional lack of muscular tone, the uterus standing up when it is in a state of systole and falling back in a state of diastole. This might be described as temporary retroversion and has no importance, except that it teaches us that, as in the old story, a shield has two sides, so in certain individuals the uterus has two positions, and that Dr. A. may diagnose the uterus to be anteverted on Monday and Dr. B. may diagnose it to be retroverted on Tuesday, and both may be right, though they will probably both think each other wrong. Then, again, there is what, for want of a better term, I would call "congenital retroversion of the uterus." There are, I expect, varieties of this condition. In one form, which is by no means rare, the backward displacement is associated with marked shortening of the vagina and often an infantile form of cervix. The uterine body is generally slightly below the normal size. It represents a form of general deficient development of the genital tract. I may say here that in such cases as these there are often no symptoms as long as the woman remains single. Upon marriage she frequently suffers in various ways. Sterility is practically inevitable and generally dyspareunia, but not always. Very often dysmenorrhoea and pelvic pains are complained of, and the patient may become very neurotic and miserable. The sterility is the outstanding feature of the case, and the mental and physical symptoms hinge on this. I believe that a congenital retroversion may exist without any mal-development, and in such cases sterility is not inevitable.

Of acquired retroversion there are certainly, in my opinion, at least two well-marked varieties. In the first, the least common, the uterine body is flaccid, lacking muscular tone. It can be pushed up by combined manipulation and anteverted. It is like an inanimate lump; if it is pushed forwards it lies forwards, and if it is pushed backwards it lies backwards.

On the other hand, in cases of acquired retroversion it is much commoner to find the uterus rigid and set in this position. I do not mean to imply that the uterus is fixed in this position by adhesions, because that is much rarer than is often thought. A uterus in the ordinary position of anteversion and antelexion cannot by manipulation be retroverted and retroflexed because of the natural stiffness of the uterine substance. So, if after childbirth the uterus sets in an attitude of retroversion and retroflexion manipulation will not antevert it, and if raised momentarily into this position by the sound, it dives back into its former position directly the sound is removed. The so-called replacement of such a retroverted uterus with the sound, is often spoken of, but it is clear that unless we have to do with a flaccid and not a stiff uterus, the procedure is a pure farce. In addition, it is convenient for purposes of description to divide retroversion into three degrees—first, second, and third. Another point of importance is to determine whether the fundus of the dis-

placed uterus lies below or above the level of the utero-sacral ligaments; in other words, whether there is or is not associated prolapse.

The first point we have arrived at is that, when it is stated that such and such a person has a retroverted and retroflexed uterus, we have only very imperfectly stated the case. We want to know what is the degree of the retroversion, whether it is probably congenital or acquired, whether the uterus is flaccid or set, whether there is evidence of imperfect development or not.

Symptoms.

In the first place, there can, I think, be no doubt that retroversion in the first degree never causes any symptoms. In the second place, I would say that in the great majority of cases any symptoms which occur are due to the accompanying prolapse of the retroverted body, and that therefore none occur unless the uterine body lies in Douglas's pouch—that is to say, has passed between the separated utero-sacral ligaments. It is quite common to find, however, the uterus displaced to this extent and yet no symptoms exist. I know quite a number of women in whom the uterus appears to be 11 days in this position, and yet they have no pelvic troubles, and lead active and often athletic lives. This fact should never be forgotten. It is none the less true, however, that some women with retroversion and prolapse complain of certain symptoms. Why this is so we do not know. Cases which appear identically alike may in one instance complain of many troubles, and in the other instance of none. This is not dependent on compression by the utero-sacral ligaments, a condition not often seen.

The symptoms that may be produced by retroversion and prolapse are iliac pain, hypogastric aching, sacral pain, and a bearing-down sensation.

Pain in the back is often supposed by women to be due to a displacement of the womb, and, of course, in some cases it may be due to this cause. It is always well to make careful inquiry as to what part of the back this pain is felt. It is hardly possible to assume that the displaced womb can account for pain elsewhere than in the sacral region. When the patient is still more closely questioned it is common to find such a pain located in one or other sacro-iliac joint, and in such cases the pain is far more often dependent on tired, poorly-nourished ligaments, or due to a rheumatic or gouty diathesis than to any uterine condition. Pain in the sacro-coccygeal joint is seldom if ever dependent on a retroverted uterus. A bearing down sensation so commonly complained of and so difficult for the male imagination to fully grasp, is perhaps the most characteristic and common of all the symptoms. Yet is it in no sense diagnostic, because it may undoubtedly be felt and complained of by women whose uteri occupy a perfectly normal position and in whom there is no descent.

It will be seen, therefore, that the symptoms generally attributed to retroversion and prolapse may occur separately or collectively in cases where neither of these conditions exist.

It is obvious that the first question to be answered is whether or not they are dependent on the position of the uterus. If, on examination, the uterus is found occupying its normal position some other cause must be sought for. If, however, the uterus is found to be retroverted, the retroversion may, in spite of this fact, not be the cause of the symptoms. This, to my mind, is of the utmost importance. It is so natural, having discovered the uterine displacement, to at once jump to the conclusion that it explains everything. In many cases it explains nothing.

It may well be asked at this point how it is possible to form an opinion, and whether under these circumstances the symptoms are or are not due to the prolapse. Although I shall deal with this matter more fully under the heading of treatment, I may say that if there are no contraindications to the use of a pessary, and if the conditions discovered are such as to render it reasonably probable that the displacement is the cause of the trouble, the uterus must be pushed up and a pessary introduced. The experimental use of the support should be carefully explained to the patient and every effort made to prevent her from getting an exaggerated notion of the importance or seriousness of the trouble. Many persons go about the world

with a totally incorrect mental picture of what they have been taught to describe as a twisted womb. It is very easy to give a woman a wrong impression; it is very difficult, having once given it, to get it out again. There is no easier way of offending certain women who have undergone much treatment, often extending over many years, than to make light of a displacement which is really unimportant and producing few if any symptoms. We therefore incur a grave responsibility if we exaggerate or overestimate the importance of this condition. I have already mentioned the main, if not the only symptoms, that can reasonably be attributed to backward displacement of the uterus. There are one or two others which I would briefly refer to, not because they are, but because they are sometimes thought to be, dependent on this condition.

I find patients are sometimes told that a retroversion of the uterus causes constipation, and this statement seems to be borne out by the fact that the investigating finger introduced into the rectum feels the uterine body projecting against the anterior wall. I do not believe, however, that this is ever the case. Constipation is so common in women, quite irrespective of the position of the uterus, that the assertion would be very difficult to prove. A strong argument against retroversion being the real cause of the constipation is that intrapelvic fibroids which press against the rectum far more effectually than the unenlarged uterus, do not seem to affect the action of the bowels in the least, at any rate until they have attained a great size. The same is true of a retroverted pregnant uterus.

Again, I would assert that, in my opinion, there are no grounds for the statement that bladder troubles, either in the direction of increased frequency of micturition or in that of retention, are due to a retroversion of a uterus of normal size. These symptoms are met with under the most varying conditions, and, although sometimes the uterus is found to be retroverted, it is not fair to attribute them to the uterine position. The length of the normal uterus is only 3 in., and the antero-posterior diameter of the cavity of the pelvis is over 4 in., so there is plenty of space for it to be in any position it likes. Temporary frequency of micturition, with or without pain, is quite a common complaint, and is often purely neurotic, and so, of course, also is retention.

A flabby, somewhat enlarged uterus, subsequent to a pregnancy, may give rise to an increased menstrual loss, but it is the imperfection of the process of involution, or the lack of muscular tone, and not the position of the uterus, which explains the menorrhagia.

In congenital retroflexion, with imperfect development of the uterus and vagina, it is by no means uncommon for the patient to complain of painful menstruation. But here, again, we must be careful not to assume that the position of the uterus is the cause of the trouble.

Does retroversion cause sterility? is a question that we often have to try to answer. There is strong evidence to support the statement that many women readily conceive with the uterus in this position. There are also good grounds for the statement that in some women it seems to make conception more difficult.

Some women whose pelvic organs are normally placed seem to conceive with the greatest possible ease, others only with comparative difficulty. With those who conceive easily the position of the uterus appears to make little or no difference, whilst with those who conceive with difficulty a retroversion may lead to a period of temporary sterility, which may be overcome by supporting the uterus with a suitable pessary. If, of course, the uterus is congenitally defective as well as retroverted, altering its position will make no difference. The sterility has an origin far more deep-seated than the displacement.

At this point I may briefly allude to sudden or acute backward displacements of the uterus. That such a condition exists is firmly fixed in the public mind, and I think even among the profession the idea finds credence. Lifting a heavy weight, a sudden strain or jar, are supposed to bring this about. If the uterus is in the normal position of anteversion and flexion its displacement backwards as the result of strain or injury I believe to be impossible. The conversion of a partly retroverted uterus into a completely retroverted uterus, or the driving down of the already retroverted uterus deeply into the pelvis, is perfectly possible, and in some cases no doubt does account

for a sudden feeling of pain as the result of lifting too heavy a weight. In a great many of these cases the pain produced is the result of muscular or ligamentous strain and has no connexion with the womb at all. There is almost always a firm conviction on the part of the patient and relatives that she has twisted or injured her womb in some way, and it is important to disabuse their minds on this point as speedily as possible. Long periods of invalidism sometimes result from imaginary injuries brought about by overlifting.

Treatment.

We will next consider certain points in connexion with the treatment of this condition. If there are no symptoms then there is no treatment—that is to say, if there are no symptoms that can be definitely attributed to the retroverted position of the uterus. To the orderly or too conventional mind a retroversion is regarded as an anomaly; an outrage on the part of the uterus. But if it causes no discomfort it is clear that any form of mechanical treatment is uncalled for. Supposing, however, that some or all of the symptoms associated with retroversion are present, before we commence treatment, and before even we allude to the condition except in the most guarded terms, we must satisfy ourselves on certain points:

1. As to the existence of the condition.
2. As to the degree of retroversion and prolapse.
3. As to whether the uterus is flabby or firm.
4. As to whether the condition is probably recent, of long standing, or congenital.
5. Whether she is single or married, and whether she has borne children.

What it all amounts to is this, Are we or are we not going to introduce a pessary? It is only by some form of mechanical support or by some form of surgical operation that the faulty position of the uterus can be modified. If the retroversion is well marked, and the fundus lies deep in the pelvis, and the patient is married, and more especially if she has borne children, the experimental use of a pessary is generally indicated, always assuming that she has symptoms.

If a woman has had a child or a miscarriage, and the womb is found to be retroverted, the retroversion almost certainly dates from the event, and if the last pregnancy has occurred some years before and the symptoms are quite recent, it is often wise to have recourse to general treatment, and not be in too great hurry to put in a pessary. If the patient is a virgin we should be very chary in advising the use of a pessary, and not have recourse to it until all other means have failed to give relief. If the vagina is short and the uterus poorly developed a pessary does no good.

Before we introduce a pessary in any case of retroversion we should form a clear idea of what we propose to do. The patient no doubt imagines that by the manipulations and the subsequent introduction of the support the uterus which was retroverted is induced to lie with its body directed forward in the ordinary common and respectable position, and this idea is sometimes, I am afraid, partly shared by the medical attendant. It is true that if, as is sometimes, though rarely, the case, the uterus is flabby in texture it may be raised up and made to lie forward, and may continue in this position after the pessary has been put in. But in nineteen cases out of twenty, although the uterus be pushed up with the fingers and even carried forward by the sound, all that a pessary will do is to overcome the prolapse, raise the fundus up out of Douglas's pouch to a higher level, and convert a third degree of retroversion into a second. If the uterus is set in the position of retroversion and retroflexion a pessary will do no more than what I have just stated.

However, it was the prolapse that caused the trouble, and as the pessary has overcome that and kept the fundus from being forced down low into the pelvis, all that is necessary has been accomplished.

The uterus is normally inclined forwards and the body bent on the neck. The only objection to its being inclined backwards instead of forwards is that it is likely to be pushed down, that is prolapsed, by intra-abdominal pressure, and a kink in the posterior wall instead of a kink in the anterior wall clearly can make no difference.

I have already alluded to the use of the pessary as experimental—that is to say, until the uterus has been

pushed up and a pessary suitable in size and shape introduced, it is not possible to determine accurately whether any or all of the symptoms complained of were due to the position of the uterus. If marked relief to the symptoms follows, as is often the case, then we know that the low-lying retroverted uterus was the cause, but if, on the contrary, no relief is obtained and the pessary employed is suitable in size and shape, then some other source of the trouble must be sought for and the pessary discarded.

If the body of the uterus in addition to being retroverted and prolapsed is markedly tender, rest in bed and hot douching should be employed for a week before any attempt is made to fit a pessary. In nearly all cases the uterus exhibits some tenderness, and pressure on it for the purpose of pushing up causes pain, but in the kind of case I allude to the sensitiveness is extreme, and to push it up without the employment of an anaesthetic would be impossible.

The cradle pessary and the ring pessary are the two kinds which are generally employed. The cradle pessary, often called a Hodge, is usually made of vulcanite, and is, therefore, rigid and incompressible. This increases the difficulty of introduction. The rubber watchspring ring is, as we all know, comparatively easy to introduce, and in those who have borne children is usually the best form to employ. After childbirth the vagina is nearly as wide as it is long, and therefore a ring-shaped instrument fits best. If, as is often the case in those who have had no children, the vagina is comparatively long and narrow, then a cradle pessary is sometimes more comfortable. A further advantage is that a vulcanite instrument is more easily kept clean. Rubber perishes with time and secretions accumulate on depressions and corrugations which form on its surface. None the less, a watchspring rubber ring is generally the best instrument to use. Those filled with glycerine can sometimes be well borne when the ordinary ring causes discomfort.

A 2½-inch ring may be regarded as the stock size. When the upper edge lies, as it should do, in the post-fornix, the lower edge should reach to within ¼ in. of the urethral orifice, and laterally it should not be so tight as to prevent the tip of the finger being swept round between it and the vaginal wall. By the use of daily douching and the removal of the instrument at intervals of six months, it can be kept clean and free from offence. The more frequent removal of the pessary is rarely desirable.

The question is often asked as to the length of time that such a support must be worn. In some cases unfortunately it is necessary to continue to use the support for many years. As soon as it is removed the old symptoms of back-ache, bearing down, and hypogastric discomfort return. In others, after an interval, the pessary may be removed without any return of the symptoms. In a few of the less severe cases the uterus may sometimes regain its normal position, and maintain it after the pessary has been taken out.

There are cases in which an operation such as ventrifixation may be advantageously performed instead of making use of a pessary. This is perhaps specially the case in young married women, who otherwise might have to look forward to many years of pessary life, and again in those in whom the vagina is so sensitive as to make it difficult or impossible for them to wear a pessary. In a virgin with a short vagina and a small uterus the operation is contraindicated.

In no case should an operation be performed unless it is clearly proved by the use of a pessary that the symptoms are due to the position of the uterus. A case in which a pessary gives no relief will generally be found to be one in which an operation gives no relief. Of all the operations performed or suggested for the relief of this condition, I believe ventrifixation to be the best.

The very progressive and up-to-date surgeon might well urge that in all cases operative treatment should be adopted and pessaries discarded. I cannot help feeling, however, that pessaries often fulfil a very useful function in these cases, and that there are quite a number of people who still cherish a preference for keeping their abdominal walls intact, in spite of the slight inconvenience entailed by wearing a pessary.

At the present time, however, although the operation is undoubtedly a useful one, it cannot be widely and indiscriminately recommended. I need not here describe the

operation in any detail. If the sutures which unite the uterus to the abdominal wall are introduced just above the level of the os internum, the body will be left free to expand if pregnancy should subsequently occur. This being so, there is no particular risk of miscarriage or of any difficulty in the course of labour at term. I have seen quite a number of patients delivered who have had their uteri fixed, and no special difficulty was encountered in the course of delivery. Moreover, after delivery the uterus showed no sign of returning to the retroverted position.

I have endeavoured to make clear my own views on this very important subject, fully realizing the difficulty of the task. It is not simply a mechanical problem which we have to consider. We know too little about the causes and effects of the condition. Still, if I have given you any food for thought and have done something to start a discussion, I have fulfilled my purpose.

OBSERVATIONS ON FOUR SUCCESSFUL CASES OF CAESAREAN SECTION.*

BY

C. YELVERTON PEARSON, M.D., F.R.C.S.,

PROFESSOR OF SURGERY, UNIVERSITY COLLEGE, CORK.

It is my desire to bring forward for consideration a series of four cases in which I have performed the operation of Caesarean section. These operations were performed during the past four years, and each of them, I am happy to say, has proved successful in the interests of both mother and child. As I have ceased for some time to take any very active part in obstetrics, these cases are presented by one who must be regarded as a general surgeon rather than an obstetrician. They will not, I trust, on that account prove the less interesting.

The indication for the operation in the first case was the presence of a large fibromyoma which completely blocked the pelvis; in the second, a contracted pelvis; in the third Caesarean section was performed at full term in a woman with a masculine pelvis in preference to the induction of premature labour at an earlier date; in the fourth case an ovarian tumour occupied the pelvis.

The first and second of these cases were fully reported in 1907,¹ so that I shall only give a brief sketch of them. The two later cases have not so far been reported.

CASE I.

This case was first seen in my consulting room on February 23rd, 1906, and was sent to me by Dr. Reid of Bandon as a case of abdominal tumour of a doubtful nature. The patient, Mrs. M., a rather anaemic and delicate-looking woman, aged 38 years, the wife of a farmer, had been married on July 29th, 1905.

History.

Previous to marriage menstruation had been regular but had not occurred since. She had noticed some enlargement of the abdomen for a few months previous to my seeing her; had no morning sickness or gastric disturbance; had some sensations of "fluttering," but no distinct quickening. Milk was present in the breasts. Dr. Reid had been unable to detect the fetal heart sounds, but found a large solid tumour presenting in the vagina.

A hard tumour was found in the pelvis, felt through the anterior vaginal wall, and extending about 4 in. above the pubis. The cervix was so high up that it could be reached with difficulty on bimanual palpation, the os, which was out of reach, being directed towards the hollow of the sacrum. Another small and partly movable tumour could be felt through the abdominal wall lying a little above the one just described. In addition I was able to detect a general swelling of a softer nature lying behind these tumours and extending somewhat above the umbilicus. This I suspected to be a pregnant uterus. The patient was admitted to the North Charitable Infirmary for observation, and on making a further examination on the following day I satisfied myself that it was a case of pregnancy complicated with fibromyomata. She was sent home and advised to return early in May, the full term of gestation being calculated for about the end of the second week in that month.

Operation.

She was readmitted to hospital on May 7th. The operation was performed on May 12th. The uterus was opened as high up as possible, and a healthy male child extracted. Haemorrhage was temporarily controlled by manual pressure. A large fibromyomatous tumour was extracted from the pelvis with

* Read in the Section of Obstetrics and Gynaecology, Royal Academy of Medicine of Ireland.