ON VENTRIFIXATION :

WITH DETAILS OF A COMPLICATED CASE.

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THE discussion on ventral fixation at the Obstetrical Society of London, reported in the *BRITISH MEDICAL JOURNAL* of December 16th, 1905, does not appear to present British gynaecology quite at its best. With the exception of Dr. Herman's admirable introduction, no address or contribution to the discussion appears to have contained much which resembled the fruits of reflection upon a varied experience.

It is easy finding fault and raising *a priori* objections, and the reader must mark a good deal of that sort of matter between the lines of the report. But the most striking contribution to our knowledge was probably that of the speaker who declared the chief indication for the operation in addition to complicated retroflexion to be the condition found in "cases of prolapse of the uterus in women at or past the menopause." In my humble judgement these are just the cases in which the operation is not indicated but altogether unjustifiable. My only experience of such cases has been in releasing the uterus from adhesions which were the result of eminently unsatisfactory operations performed recently or more remotely by others.

But the chief defect of the discussion appeared to me to have been the all-pervading influence of the logical fallacy of comparing unlike things. Under the collective term "ventral fixation" all sorts of operations, good and bad—chiefly the latter—appear to have been discussed and their results appraised, just as if the term implied some simple surgical act.

According to the report, Dr. Horrocks said that in cases of adhesions "the operation became much more difficult and dangerous," and even Dr. Herman, in speaking of adherent retroflexion of the uterus, stated that the operation was to be advised cautiously, because, among other reasons, "in these cases it was more dangerous."

The ground for these opinions I cannot imagine. I have read the report while preparing 100 cases of ventrifixation for publication. No case has given any anxiety in the early post-operation stage, and complete relief from symptoms has resulted in all save one doubtful case. The exception is that of a woman who presents all the anatomical conditions characteristic of cure. Her remaining symptoms are purely subjective, and, owing to domestic circumstances, she is under great temptation to remain an object of commiseration, and to postpone the evil day when she must cease to depend on her relations. It has occurred to me that under present circumstances an illustrative case involving all the supposed difficulties and dangers of ventrifixation might be of interest to your readers, and especially to members of obstetrical and gynaecological societies.

So far from acting in the belief that adhesions resulting from pelvic peritonitis add to the danger of ventrifixation, I have always assumed that a peritoneum which has been devastated by peritonitis is less likely to become infected than the virgin structure; and I must say that the results have appeared to support the theory and practice.

My "precursory communication," then, to literally translate the well-recognized German term, embraces the facts of the following case:

History.

M. D., aged 29, married five years, had two children, both living, eldest 4 years, youngest 2 years and 9 months. At her first confinement she was attended by a midwife, who was drunk all the time of the labour. The patient became very ill, but the midwife did not consent to seeking medical advice for five weeks. Dr. Floyd was then called in, and at once advised the patient to seek admission to Chorlton Union Hospital. She was there for eighteen weeks, and during the time she had "several" abscesses in her breasts opened by the visiting surgeon. The patient has never been well since her confinement. Her previous history is clear and simple. She began to menstruate at 15, was always regular, and had no dysmenorrhoea. She was married at 24, and became pregnant during the first year of her married life. She became pregnant a second time, and was in great distress during the whole period of gestation with pain in the "stomach," and especially in both groins. The symptoms continued without intermission until her confinement. At her second confine-

ment she was attended by a nurse from Withington Workhouse Hospital. The nurse was very attentive and helpful, and the patient had a "good time." She was in bed for twenty-one days, had a great deal of trouble with her breasts, and was not able to suckle the child at all. From that time she has been always ailing until she came under treatment as an out-patient at the Southern Hospital early in 1904. She was continually uncomfortable, but she suffered severely at her menstrual periods, which were quite regular, and continued seven days. At these times she was just able to keep out of bed.

Condition on Admission.

Abdominal Examination.—Tenderness on palpation of hypogastrium, and especially in the left ilio-inguinal region, with involuntary resistance to manipulation; no tumour.

Vaginal Examination.—Lax vagina and pelvic floor; split cervix, with tender band stretching across left lateral fornix; acute retroflexion of the uterus; thickening and matting of tubes and ovaries on both sides.

After rest and tampons and the usual palliative treatment for over a month without any improvement, it was decided to perform the operation of ventrifixation, with as conservative treatment of the appendages as circumstances would permit. The patient was an emaciated, anaemic, and unhappy-looking little woman, and the first intention had been to remove the appendages on both sides; but, considering her age and certain social circumstances, the more conservative treatment was finally resolved upon.

Operation.

On July 6th, 1904, abdominal section was performed. The ovaries and tubes on both sides seemed to be hopelessly bound down by adhesions, and it was difficult to reach the fundus uteri, which, owing to adhesions, could be only obscurely felt in the lowest part of the pelvis. After the uterus had been to some extent released it was possible to gouge out the ovaries from their fosses and to bring each in succession into view. On the right side the Fallopian tube was thickened, closed, with bulbous end, and firmly adherent to the ovary. On the left side the ovary was smaller, and covered with the usual red shreds of broken-down adhesion tissue; the tube was open, the fimbriae presenting an almost normal appearance.

The right ovary received attention first. Only a part of it, from one-half to one-third, appeared to contain follicles, the rest consisted of hard, sclerosed, white fibrous substance, with a verrucose surface. The hard portion was excised in the form of a wedge, and the edges of the hard tunic brought together by fine catgut sutures. The tunic of the ovary was punctured, and slight incisions made in two or three other places, the shreds of adhesive tissue were snipped or scraped off, and the remains of the ovary were then released and allowed to drop. The right tube was then incised from the end inwards along the upper margin for about one-third of its length, and a fine probe was passed along the canal till stopped by the wall of the uterus. In probing no force was used or required. Sutures were then introduced so as to bring together the serous and mucous layers of the wall of the tube round the incision, and the tube was dropped, having now a large ostium abdominale, and with it freedom of movement completely restored.

The left ovary was next treated in a similar manner. The proportion of sclerosed tissue was larger than in the right ovary, but it was not so hard. It was cut out in the same way as on the right, but perhaps it would have been sufficient to make incisions into the obviously thickened tunic of this ovary in order to eliminate its contribution to the sufferings of the patient. It was not necessary to interfere with the left Fallopian tube.

The uterus was now completely freed from the remaining adhesions, and the fundus was brought well up for inspection and the more obtrusive shreds of adhesion tissue were removed. The operation of ventrifixation was then performed with careful detail. This was a complete hysteropexis abdominalis. The vesico-uterine cavity was first closed by catgut sutures placed so as to give the largest possible amount of space for the bladder. The rest of the sutures were fine silk, so inserted as to draw upon the peritoneum and fascia only in order to retain the uterus in the position most nearly resembling the normal. The last sutures introduced included, in sequence, fascia and peritoneum, then uterus, and peritoneum and fascia. The highest were transverse, and reached rather higher than the upper limit of the lower half of the corpus uteri. These sutures were inserted exceptionally high up, owing to the extreme improbability of pregnancy ever occurring again.

The abdominal wound was closed in stages with catgut, fine silk, and silkworm gut. It is hardly necessary to add that all sutures penetrating the peritoneum were buried.

The last step in the operation was the introduction of a large Hodge pessary with glycerine bulb in order to prevent as far as possible the weight of the uterus from depending upon the sutures.

After-History.

The recovery was quite uneventful, the only point worth mentioning being some temporary irritation of the bladder beginning on July 19th.

Owing to the poor state of health of this patient on admis-

sion, she was kept in the hospital for rest and nursing until August 8th.

Posterior Colporrhaphy.

The patient was again admitted in the end of November in order to undergo the operation of posterior colporrhaphy. Her symptoms then appeared to result from dragging of the freely-movable uterus upon its artificial adhesions owing to the want of support from the pelvic floor. Menstruation since the operation had been regular, almost painless, and the period lasted only from three to four days. General health greatly improved. The operation of colporrhaphy was performed on December 14th, 1904. There was nothing in the operation or after-history worth recording. The patient was discharged apparently well on January 2nd, 1905, and was lost sight of until she presented herself as an out-patient in November, 1905, complaining of some discomfort in the region of the cicatrix. She was admitted for observation early in December, and was found to be pregnant about twelve weeks. Careful palpation of the cicatrix appeared to show that there was unusual dragging on the adhesions between the middle of the corpus uteri and the abdominal wall. The other symptoms were merely those characteristic of normal pregnancy.

It would be out of place to discuss principles and to generalize on the report of an individual case, however remarkable. Still my experience of a great variety of cases with wonderful similarity in the results leads me now, in calling attention to the operation of ventrifixation by means of a striking case to deprecate the pessimism running through the discussion to which reference has been made. I deplore also the *obiter dicta* tone of the pronouncements of men whose views might do so much good or harm among medical practitioners who fortunately have to be consulted before operations are decided upon. In reading many reports upon this operation from Europe and America, I find the judgement of Hofmeier comes nearest to my own conclusions:

As the final result of observations carried on for a considerable series of years, it may be confidently stated that the operation of ventrifixura uteri properly carried out... has established for itself an eminently distinguished position in the treatment of displacements of the uterus, and that Olshausen, in introducing it, has conferred a great and permanent benefit upon operative gynaecology.

THE IMMEDIATE AND REMOTE RESULTS OF THE HIGH OPERATION FOR VARICOCELE,

WITH A REPORT ON THE EXAMINATION OF 100 CASES.

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As all surgeons know, it is exceedingly difficult to keep in touch with cases of varicocele after operation, chiefly owing to the fact that so many of the patients subsequently enter the public services. Consequently, though 100 cases do not seem very many on which to base the results of a common operation, yet, under the circumstances, the number is extremely gratifying, as even to see these more than 500 patients were written to. Before proceeding further, we desire to thank the surgical staff of St. Thomas's Hospital for their kindness and courtesy in permitting us to examine their cases. In all seen the high operation had been performed, and in the majority the wound had healed by first intention. After exposing the cord by a short incision the pampiniform plexus was isolated, ligatured in two places about 2 in. apart, and the intervening portion excised. In some cases the two ends were approximated by a suture which transfixed the stumps, whilst in others this little detail was neglected. This step is an important one from the patient's point of view. When the stumps are sewn together a continuous cord is the result, and we have known men refused admission to the army, police, etc., being told that their operation was a failure. It is better to omit this step in candidates for the services. The results of this operation may be conveniently divided into immediate and remote.

A. IMMEDIATE RESULTS.

Haemorrhage.

With modern methods of haemostasis this is a rare

complication, and as such would have been omitted had it not an important bearing on the after result. Slight haemorrhage, such as would occur in connexion with a damaged vein, leads to the formation of a haematoma; this, by pressure upon the remaining veins of the pampiniform plexus, is a potent factor in producing oedema and thickening of the scrotum, subjacent tissues, and testis. In all the cases in our series where a post-operative haematoma was noted these changes were also found. In some instances, fortunately rare, haemorrhage is due to slipping of the ligatures, dependent upon a faulty knot or defective material. In those cases in which the divided ends of the pampiniform plexus are approximated by tying the ends of the proximal and distal ligatures together it is quite conceivable that the traction exerted by the testis would lead to the slipping of one of them. That this does occur has been proved from time to time, hence this method is to be deprecated. In two cases it was noted that the pelvis was filled with blood which had escaped from the retracted end of the spermatic artery projecting through a rent in the peritoneum. This naturally leads the surgeon to imagine that he has accidentally wounded the serous membrane at the primary operation. We believe, however, that such is not the case, and that the rent in the peritoneum is due to the pressure of the blood effused in the inguinal canal; when this escapes into the peritoneum the patient shows marked signs of severe internal haemorrhage together with a rapidly-increasing pelvic swelling.

The warning, if haemorrhage is occurring after an operation for varicocele, is that the patient complains of pain. The scrotum should always be examined when this complaint is made.

Orchitis.

Inflammatory changes in the testis were noted in several of the cases in our series (5.6 per cent.). In some the change was acute and occurred from the third to the sixth day, whilst in others it was either subacute or chronic, and was characterized by definite hardness and thickening of the testis. In no cases was suppurative orchitis recorded. If this form of orchitis is regarded as being due to the presence of pyogenic micro-organisms it is difficult to understand why the wound in all these cases healed by first intention; consequently, the only plausible explanation is that of passive hyperaemia following the sudden removal of some of the afferent and efferent blood vessels. The after result must now entirely depend on the collateral circulation. If it is rapidly and well developed, the testis returns to its normal size and all acute symptoms subside; but if, on the other hand, the collateral circulation is imperfect, then the testis and scrotal tissues are thickened permanently. This leads to the discussion of a third complication, namely:

Oedema and Thickening of the Scrotum, Enlargement of the Testis, and Hydrocele.

If these tissues are carefully examined about a week after the operation some alteration in their consistence will be noted in nearly all cases. In addition to this thickening, which affects the skin, scrotal tissues, and testis, a flaccid hydrocele will be frequently found. This, therefore, may be regarded as the germ of similar changes which will be described as "remote."

Suppuration.

Septic infection may nowadays be regarded as a comparatively rare complication. With aseptic methods the suppuration percentage at St. Thomas's Hospital, over a period of three years, works out at 4 per cent. This fact is mentioned in order to show that the remote results are not due to inflammatory induration of septic origin.

B. REMOTE RESULTS.

The Testis.

Of all the conditions found after the operation for varicocele none were so constant as changes in the consistence of the gland itself, which were due to the formation of fibrous tissue. In many instances this is easily demonstrated by the greater hardness of the testis as compared with its fellow. When present in lesser degree, it is recognized rather by loss of elasticity than by actual hardness, and is most readily detected by absence or impairment of the sensation of fluctuation yielded by the normal gland of the opposite side. Such fibrosis was sufficiently gross as to be recognized in 84 per cent. of the