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ON

MINOR DISPLACEMENTS OF THE UTERUS AS
A CAUSE OF DISABILITY IN WOMEN.

BY

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In disorders of the female pelvic organs, as in general medicine, the cause is readily determined if there is an obvious gross lesion, such as an inflammatory mass or new growth, but difficulty arises when evidence of localization is uncertain and physical signs absent or trifling. The problem is then one of interpreting the meaning and estimating the importance of some minor deviation from the average, and deciding whether it falls within the limits of normal anatomical variation or can be held responsible for the patient's symptoms.

There is a personal factor in the interpretation of symptoms with little in the way of physical signs, and among gynaecologists, as among physicians and surgeons, there will be many individual differences of opinion. There are two extremes—the mechanical school and the psychical school: the former will find for all disorders of function, particularly in the abdomen and pelvis, some kink or twist or displacement which satisfies them as the cause of the trouble, while the latter will ascribe the chief part in the production of the patient's disability to some subconscious mental process or repressed or unexpressed sexual desire. No doubt as time goes on the true mean between these extremes will be reached, but meanwhile the bent of mind of the individual observer will largely determine on which of these factors the stress will be laid.

I propose to discuss this afternoon the minor displacements of the uterus—that is, excluding obvious descent—and to attempt to estimate their importance as a cause of disability in women.

Looked at from the historical aspect, it will be seen that uterine displacements came into special prominence in the mid-Victorian era—a time when it was exceedingly difficult for a woman to have her uterus just as it ought to be, as it was thought that its proper position should be in the axis of the pelvic inlet; if it was in front of that position it was looked upon as anteverted or anteфлекed, and if behind as retroverted or retroфлекed. Now all displacements have died a natural death except the backward one, which, as the last survivor, has inherited all the wealth of the family in the way of symptoms. An index of the change in attitude towards these uterine displacements can be obtained by glancing at the edition of *A System of Gynaecology*, edited by Allbutt and Playfair, published in 1896, and its successor, *A New System of Gynaecology*, by Eden and Lockyer, published in 1917. In the 1896 edition Professor A. R. Simpson of Edinburgh describes in detail uterine displacements, forward, and backward, and sideward, so that we find mentioned even dextro- and sinistro-versions and flexions, though with an obvious mental reservation as to whether the anterior displacements ought not to be eliminated altogether from the category of uterine disorders. In the *New System of Gynaecology* of 1917 the displacements have disappeared entirely, except the backward, which is the only one considered. The author of the article, Professor Chipman of Montreal, summarizes his views as follows:

"All these signs and symptoms may be found with no retroversion whatever, for these may result from altogether different causes. Their presence is in no sense pathognomonic of this, or of any uterine displacement, and so the displacement may be but a coincidence and possess no etiological significance whatever.

"In actual practice it is fair, I think, to regard retroversion of the uterus unaccompanied by prolapse as of no importance save only as a certain predisposition towards prolapse. It is specially wise in these cases to treat the symptoms of which the patient may complain upon general and broad lines, rather to avoid than encourage local treatment, and only if the general treatment fail—and this in my experience will rarely be the case—is one to attend in any way to the 'backward displacement.'"

What was not appreciated by the older gynaecologists was that the uterus is an organ which is liable to great variation in position as the result of changes in the surrounding viscera and in the intra-abdominal pressure, that its blood supply and attachments are arranged to permit of its being

either a pelvic or abdominal organ, and that it is perfectly comfortable with its fundus on the pelvic floor or just under the diaphragm. It is now generally recognized that its position, *quâ* position, is of no clinical importance, and that what we have to look for is the cause of the unusual position and consider whether that cause is one requiring treatment. The most common cause of retroversion is prolapse of the pelvic floor, of which the uterus forms part; usually retroversion with descent is the first indication of prolapse. Infections, including subinvolution, are a cause of simple and fixed retroversion; growths, such as ovarian cysts and uterine fibroids, are another cause of displacement of the uterus; and a rarer cause is maldevelopment, occasionally seen in nulliparae.

Retroversion is very common in multiparae, and is occasionally met with in nulliparae when examined for dysmenorrhoea or sterility, or because of symptoms which might have a pelvic origin. In the latter the backward position is classed as a congenital peculiarity, but until figures can be obtained by investigation of large numbers of healthy girls and women so as to obtain an idea of the frequency of the retroverted, as compared with the anteverted, position, it is impossible to dogmatize on its clinical importance. It may tend to sterility and abortion; though occasionally found when dilating for dysmenorrhoea, it is very much rarer than the usual anteverted and anteфлекed position, so that, until statistics as to the percentage of dysmenorrhoeas with backward and with forward position of the uterus are obtained and compared with the incidence of these positions in nulliparae generally, it is impossible to make positive statements. Some of these retroverted and retroфлекed uteri in virgins with dysmenorrhoea are small and infantile and associated with scanty menstruation, just as is seen with the small anteverted and anteфлекed uterus, and thus it would appear that incomplete development, and not the forward or backward position, is the determining factor in the production of dysmenorrhoea.

In parous women the uterus is often found to be retroverted because pregnancy and labour and lying-in are the factors which tend to produce this position; in multiparae with a relaxed abdominal wall and enteroptosis the backward is almost as common as the forward position. The softening of the uterus and its attachments and the stretching of ligaments and muscles during pregnancy, the further stretching and laceration during labour, the dorsal position, overdistension of the bladder, the assumption of the erect position and the resumption of work before involution is complete, are all predisposing factors.

It may be worth while to consider in detail the symptoms commonly ascribed to the backward displacement.

Backache, a symptom of nearly every pelvic disturbance, is probably more common among women with retroversion than anteversion because of the frequency with which abdominal wall and pelvic floor weakness, enteroptosis, subinvolution, and other enlargements of the uterus are associated with a backward position. As backache is largely a fatigue effect and the symptom *par excellence* of the tired woman possibly this fatigue may appear earlier when the uterus is back than when forward, and, if so, probably because of the associated conditions rather than the mere uterine position.

Bearing down is a sensation so closely associated with weakness of the sustentacular structures that its occurrence with retroversion should at once suggest that pelvic floor weakness is the cause, and that the position of the uterus represents an early stage of prolapse. With a lowered resistance to disagreeable sensations, other varieties of aching and pain will occur as an early result of fatigue, and are commonly attributed to retroversion, if it happens to be present.

Menorrhagia is another symptom said to be more common among women with retroverted than with anteverted uteri. There is an armchair hypothesis, generally swallowed without much hesitation, that pelvic pain and aching, menorrhagia, and leucorrhoea are due to a uterine congestion from an obstruction to the venous return. Beyond the fact that such theory forms a reasonable explanation for the above symptoms, and that these symptoms are sometimes cured by the uterus being supported in anteversion, I know of no observations in support of this hypothetical passive congestion and many points which it leaves unexplained. This menorrhagia is quite haphazard in its occurrence, and the majority of women with retroversion do not suffer from it; there is no naked-eye or other evidence of passive congestion observed when operating, by abdomen or vagina, in cases in which the uterus is retroverted; the remote

pathological effects of a chronic venous congestion are not seen in old-standing retroverted uteri; on the other hand, the hyperplasia of the cervix in prolapse is the effect of a passive congestion, which, however, does not produce menorrhagia. Menorrhagia from this presumed congestion is absent from, and is not characteristic of, the uterus pushed backwards by an ovarian cyst or other tumour in front of it, a condition in which obstruction to the venous return would appear more likely than in a simple retroversion.

Leucorrhoea is another symptom which it is not possible to say is relatively more common with retroverted than anteverted uteri; it is certainly almost invariable with retroversion and subinvolution, and with laceration and infection of the cervix. There is no proof that the retroverted position, apart from laceration and infection, increases the uterine secretions.

Dysmenorrhoea of the so-called congestive type, explained also on the presumption of a venous congestion, is a rare accompaniment of simple retroversion, and, when present, is commonly due to some complicating infective process.

Disturbances of micturition are not caused by a simple retroversion. Retention may result from the incarceration in the pelvis of a retroverted uterus, enlarged by pregnancy or fibroids to a size big enough to cause impaction; incontinence on coughing or straining may accompany retroversion with trifling pelvic floor descent; frequency does not result from a simple retroversion.

Pressure on the rectum and tenesmus are occasionally complained of, and constipation is sometimes attributed to the two-ounce uterus leaning against the rectum. If the index finger is passed into the bowel and the finger-tip merely bent forwards against the fundus felt through the anterior rectal wall, it will suffice to raise the uterus from the bowel; it is difficult, therefore, to imagine how the progress of a faecal mass weighing much more than two ounces and propelled by peristalsis would be hindered. Haemorrhoids have also been attributed to the uterus lying back and pressing on the haemorrhoidal veins, and it cannot be denied that constipation and haemorrhoids are common in women with retroversion, as they are in women without it.

Dyspareunia is sometimes present with the uterus retroverted as it is with the uterus anteverted. It is probably due to prolapsed ovaries or to accompanying inflammation and not to the uterine position itself.

General disturbances—headache, sickness, indigestion, and abdominal pain—have all been included as counts in the indictment of the backward displacement, but without any justification whatsoever, owing to too much concentration on the mechanical factor and entirely overlooking the question of fatigue of mind and body and what it may produce. So much loose thinking has been associated with the subject of "displacements" that statements begging the whole question are frequently made, and quite seriously, in medical papers and in discussions at societies—as, for example, that "retroversion requires treatment when it causes symptoms." On inquiry these symptoms will be found to vary with the fancy of the individual, and may be widespread enough to include uterine headaches and indigestion and perhaps even a uterine cough.

If a somewhat similar reasoning to that of the postulates for proving the causative bacterial agent in an infective disease were attempted it would fail to show any connexion between retroversion and the symptoms attributed to it. First, because there is no symptom-complex peculiar to retroversion; second, because such symptoms as are ascribed to the retroversion do not occur invariably, but only occasionally; and finally, because changing the position to an anteversion does not necessarily do away with the symptoms ascribed to the displacement. I once tried to keep a record for the instruction of my students of those women coming to the gynaecological out-patient department with simple retroversion without symptoms, of those with the traditional symptoms and no retroversion, and of those with the retroversion and no symptoms. Unfortunately my figures were destroyed in a spring cleaning epidemic, and all I can remember is that the largest group was that of women with the supposed symptoms but without retroversion. Statistics from a gynaecological department are, however, of little value, as the routine examination of women without pelvic trouble is necessary to a knowledge of the frequency of retroversion without symptoms. Figures are given, varying between 15 and 30 per cent., of the proportion of women in whom the uterus is deviated backward, and attempts have been made to estimate the proportion in which the retro-

deviation caused disability, but naturally are valueless because they represent merely the personal view of the observer.

Individual opinion can be eliminated, however, by noting the gradual disappearance of "displacements" from the time of their vogue and predominance in gynaecology—a time aptly summarized in Clifford Allbutt's remark that "the uterus could justly complain that it was always being impaled on a stem or perched on a twig"—to the present day, when the retro-deviations alone obtain a grudging and hesitating adherence from writers in textbooks and treatises. The reason they have survived so long is twofold: first, retroversion is present with other pelvic conditions causing disability, in which the position of the uterus is often the most striking feature on examination; and secondly, that due importance has not yet been given to the psychical factor and fatigue by those who cannot look beyond anatomical variations. It may be thought that if retroversion is part of pelvic floor prolapse or subinvolution it matters little if the woman's disability is ascribed to the position of the uterus, but further consideration will show that the point is important.

Those who have been brought up on and have accepted the displacement doctrine will consider retroversion as capable of explaining symptoms it cannot cause, and will be satisfied with it as an explanation of acute pelvic pain, uterine haemorrhage, intestinal stasis, and even partial obstruction, and look no farther for a cause. A retroverted uterus may readily be mistaken for a small swelling adherent to the back of the uterus, and I have known of a tubal gestation, an inflammatory swelling in the pouch of Douglas, and a rectal carcinoma being taken for a retroverted uterus because of the idea that this position of the uterus could be responsible for the patient's symptoms. Not only are errors in diagnosis made more likely but wrong treatment follows if attention is directed solely to the position of the uterus. The displacement myth has produced far more invalidism and inefficiency in women than any good it has ever done. The knowledge that her womb is "misplaced" or "twisted" is a source of mental distress to the unfortunate woman who is treated for it; the wearing of a pessary and its frequent changing concentrates her attention on her pelvic organs, and she becomes convinced of her uterine weakness, which must always be considered and prevents her doing what others do. Thus is the pelvic neurasthenic manufactured, particularly among single women.

I would suggest that we follow Sir Thomas Browne's dictum that "knowledge is made by oblivion, and to purchase a clear and warrantable body of truth, we must forget and part with much we know," and I would urge that the time has come to let the backward positions of the uterus go the way of the other displacements.

In child-bearing women many of you know from your own experience that backache and bearing down are relieved by replacement of the uterus and a pessary, because, as already explained, the symptoms are caused by strain on the supporting structures. In virgins the problem is quite different, and I would lay it down as a rule that in their case pessary treatment should never be adopted; the cases in which it might be justifiable are too exceptional to affect the general applicability of the rule. In nulliparous married women temporary pessary treatment may be tried for sterility and repeated miscarriages.

In the parous woman simple retroversion is often found with an unusually mobile uterus and ptosis of the contents of the abdomen and laxity of the wall. With general enteroptosis the backward position is more common than the forward, and must be looked on as merely a fraction of the general relaxation; it would therefore show a wrong perspective of the case to concentrate solely on the uterus to the neglect of the general abdominal condition. In many cases there is also weakness and descent of the pelvic floor. The bulky subinvolution and retroverted uterus following labour is to be treated as primarily subinvolution and chronic infection, but, as will be seen later, benefit may come from its being supported, as subinvolution affects its ligamentary attachments as well.

The cases which the practitioner treats with success as cases of retroversion are almost entirely cases of slight pelvic floor injury and subinvolution, often complicated by overwork and overstrain with fatigue symptoms. The treatment of such cases is worth detailed consideration, as success largely depends on general management as well as relieving the pelvic condition.

The preventive treatment is clearly good midwifery,

avoiding laceration and infection, and a physiological management of the puerperium. During the lying-in time measures directed towards the promotion of normal and complete involution should be adopted. The patient should be encouraged to sit up and move about in bed. The binder, which restricts the movements of the abdominal muscles, should be discarded as soon as possible, certainly within a week, and massage and breathing exercises begun as soon as the free lochial discharge has lessened and the patient's general condition allows. When the fundus uteri has sunk down so that it is only just palpable in the abdomen, the woman should be encouraged to assume the knee-elbow position for short intervals and afterwards to lie prone for a time. While in the knee-elbow position a good exercise is to make her contract her levator ani muscles by the action of "squeezing up as if to hold a motion." In this position the strain on the pelvic floor is at its minimum, and the muscles therefore work at an advantage. Another exercise for restoring the efficiency of the levator muscles may be carried out with the patient on her back by combining their contraction with that of the adductors of the thigh. The nurse may be instructed to resist adduction by placing her hands on the inside of the knee while the patient tries to bring her knees together, the resistance being slight at first and increasing as time goes on. Indeed, all muscular exercises, particularly of the abdominal, flank, back, and thigh muscles, are valuable by improving the circulation and physical condition. Breast feeding, in addition to its importance to the infant, should be encouraged for its effect in aiding involution. Though the lying-in mother requires two, or if possible three, weeks of a rest cure after the strain of pregnancy and labour, and as a preparation for the nursing and care of her infant, that time should not be one in which her muscles are allowed to become soft and flabby, so that they are incapable of performing their functions when she gets up, and nothing is so valuable as resisted muscular movements. By aiding the recovery of the abdominal and pelvic musculature and keeping up the general physical condition whilst giving the mother rest and relief from household duties and strains much can be done to lessen the frequency of retroversion and descent of the uterus, with the backache, forcing down sensations, and early fatigue that detract from the efficiency of so many mothers after child-bed.

When advice is sought for symptoms of this nature shortly after labour, and a bulky retroverted uterus is discovered on bimanual examination, it should be replaced and kept in position by a pessary. This is, however, but a small part of the management of such cases. The support by the pessary will probably allow of outdoor exercise being taken so that the general physical condition may be improved. Relief from indoor and exacting duties may be difficult to secure, but is a more essential matter than the pessary. If, as is usually the case, the patient is a tired and overwrought woman, a pessary is a poor substitute for the rest she needs. It is in regard to this type that the concentration on the mere position of the uterus so often fails to restore the woman to efficiency. Many of these tired mothers are referred to me because the position of the uterus is pitched on as the very head and front of the offending. On investigation the woman may have four or five young children, and little help with them and her household duties; she has a holiday of a few weeks each year, but the only change to her is one of venue, from her own house to rooms at the seaside, where escape from the children is even more difficult than at home. Perhaps she has never had more than a day or two's relief from her family cares, and it is not surprising that she should have the characteristic symptoms of the tired mother, that she is depressed and unfitted for her duties by aching back and legs. It matters little that her uterus is retroverted—it has been so for years; but it matters a great deal that she has relief from the constant strain that has worn her out and that her physical condition as a whole is improved.

Some of these women with simple retroversion have all the subjective sensations of prolapse; indeed, they often come with the complaint that "the womb drops," though they have no protrusion and nothing is discovered on examination, except that the uterus is lying back and perhaps a little low. Doubtless the symptoms are due to pelvic floor weakness with strain on the uterine supports. Great relief is usually effected by replacement and a pessary, by exercises similar to those described for the lying-in mother, by graduated outdoor exercise short of fatigue, and relief from the day-in and day-out strain of family and household.

In the course of three or six months, if the physical and nervous condition has improved, the pessary can be left out.

Such patients are liable to a return of their symptoms when run down or overtired, and some will ultimately develop definite prolapse, for which operative treatment will be required. The point I wish to emphasize in regard to these and similar cases is that pessary treatment alone will not suffice, but exercises and general management of the patient are essential to success.

Pessaries are valuable for temporary use—to give support till the patient's condition has so far improved that they are no longer needed. If the disability returns after removal of the pessary, some surgical procedure is far better than permanent pessary life.

The multitude of pessaries, intrauterine and vaginal, which marked the displacement era of sixty years ago, have almost all disappeared into museums as antiquities or curiosities, and now the ring is almost the only survivor. In the surgical area through which we are now passing the modern counterpart of the pessary inventor is the deviser of suspensory and sling operations on the uterus. The variations in detail of these procedures are legion, and the woman with a uterus that will not sit up straight can have a tuck taken in its round ligaments, or have it held up by the ligaments being stitched to the abdominal wall, or delicately supported by the ligaments being clasped behind its back, and so on *ad infinitum*. The attitude of mind of these suspensurers of the uterus is precisely that of the mid-Victorian pessary-monger; their methods only have changed with the times, and these operations are quite as much overdone as the pessaries were, but do less harm. There is not the bad mental effect of continuous pessary wearing with the recurrent need for changing, and there is the advantage that the patient has two or three weeks in bed with a change and convalescence, together with the strong suggestion that now her errant womb has been made right she also ought to be right.

Many of the women on whom such operations are done have an oversensitive nervous system, and at a time when their powers of resistance to disagreeable stimuli and sensations of fatigue are particularly low, owing to illness or overstrain, they are examined, the uterus found in the retroposed position, as it had been for long past, and an operation is promptly performed. When there is a fixed retroverted uterus with chronic inflammation an abdominal operation is necessary for the removal of the affected tubes, and it is as well to fix the uterus up at the same time. Suspensory operations may also be tried for sterility and repeated miscarriages, and in single women to get rid of a pessary or as a measure of desperation when all else has failed. Though they may be combined with operations for prolapse, alone they are not sufficient for that condition.

SUMMARY.

In case the arguments of my paper should not be obvious, its chief points may be summarized as follows:

1. Always look beyond the mere position of the uterus and do not ascribe symptoms to retroversion.
2. In retroversion accompanying pelvic floor prolapse, subinvolution, pelvic inflammation, and tumours, the disability is due to the primary condition and not to the position of the uterus.
3. Retroversion after child-bearing with subjective symptoms of prolapse is correctly treated by replacement of the uterus and a pessary, provided the relief of fatigue is also secured and attention paid to the general health, mental and physical, and to the improvement of the abdominal and pelvic muscles.
4. If recovery does not follow after six to twelve months operative measures will give better results than continued pessary treatment, and probably perineal repair and plastic vaginal operations will be more satisfactory than those of the hysteropexy type.

REPORTS of cases of epidemic jaundice have been received by the New York State Health Department from almost every part of the state, and the disease is epidemic in adjoining states.

DURING 1921 35 cases of leprosy were reported in New York, an increase of 7 as compared with the previous year; of these cases 12 were in municipal hospitals, while the others remained at home pursuing their usual occupations. All are periodically examined by an inspector of the Health Department, and treatment by chaulmoogra oil is regularly carried out.