objections are—1st. It is not certain that the contaminated gland contains all the virus. 2nd. It cannot be reduced to general practice, as the glands are frequently so situated as to render their extirpation impracticable or dangerous. 3rd. A bubo is so frequently discussed, that the risk of suppuration does not justify the pain and danger of the operation; in short, it is a plan which cannot be relied upon, nor attended with any possible advantage.

If, on being first consulted, the surgeon find that suppuration has commenced, it will be proper, notwithstanding, to recommend mercurial friction immediately; for this will often so diminish the size of the swell as to leave it when it bursts no larger than a common boil. No advantage will be gained by waiting till complete suppuration takes place; on the contrary, the ulcer will not heal so well without the adhibition of mercury.

The same external remedies may be employed to promote suppuration in this case as in any other phlegmonous tumour; linseed-meal poultices will be the best, and the abscess ought not to be opened till it is near to breaking.

Various modes of opening these abscesses have been recommended; some open them by puncture; some by caustic; whilst others leave them to time. Some propose a large, and others a small, opening. The truth is that no precise rule can be given on this point. In the purely phlegmonous bubo, where only one gland is affected, and where the skin is quite sound, it may be opened by making a small puncture in the most prominent and depending part; and when the matter has been squeezed out, compresses moistened with Goulard's wash should be applied, and maintained in their position by a flannel roller. In this way the part will sometimes heal in six or seven days.

Should this mode of treatment be considered as likely to prove inconvenient, the abscess may be allowed to rupture spontaneously, and be subsequently treated by poultices or soap cerate.

The result of these abscesses most to be dreaded is an extensive ulcerated surface; this seldom occurs where the skin is sound; but when it is in a morbid condition, the ulcer may not heal for six or eight months.

[Had Mr. Pearson been acquainted with the curative power of that extraordinary medicine, the iodide of potassium, in such a case, his prognosis would have been very different.]

When the superincumbent skin, the absorbent glands, and parts below, are found to be diseased, the bottom of the abscess ought to be exposed by removing the skin with a double-edged knife, carried in a circular direction around the morbid surface; dry lint may be applied to the cut edges, and the following day a linseed-meal poultice, after which the ulcer may be treated with green digestive ointment till it granulates. If after a

fortnight the sore assume a marbled appearance, it should be sprinkled with red precipitate powder, dressed with red ointment, and a pretty tight bandage applied.

Particular attention is to be paid to the edges of the sore; they are to be kept soft and even by lunar caustic; and if this should not succeed, a plaster should be applied every day in which there is a small quantity of corrosive sublimate.

(To be continued.)

ON RETROFLEXION OF THE UTERUS.

A PAPER READ BEFORE THE MEDICAL SOCIETY OF KING'S COLLEGE, LONDON, NOV. 18, 1847.

By FREDERICK JOHN HENSLEY, M.B., Lond., Vice-President of the Society.

Mr. President and Gentlemen,—

The subject which I have the honour of bringing under your notice this evening is one of considerable interest and importance. The diseases of the uterus have been hitherto much neglected by the profession, and are in general but little studied by the student of medicine in this country, and consequently, the profession, as a body, are to a great extent ignorant of their diagnosis and treatment; yet, without a knowledge of uterine disease, both functional and organic, it is impossible satisfactorily to treat the numerous disorders to which the female sex is liable. It may be well then to consider the causes of this general neglect, and the means best adapted to remedy it in future.

At the root of this evil I place the want of clinical instruction in uterine diseases, a want dependent partly on the nature of the diseases themselves, which must ever render their demonstration to numerous students difficult, and in part on the natural and laudable repugnance of the sufferers to indiscriminate examination and exposure, and the delicacy with which it is the duty of every physician to conduct such investigations. It is true that the English student may find an ample field for such investigations and studies in the Continental schools, but few, comparatively, can avail themselves of such advantages; and many of those who do, and who are ill-prepared by their previous studies to make the best use of them, are apt, on their return, with a short sighted policy, to sneer at those who would rationally investigate uterine disease by the employment of such means as aid the senses,—I mean the speculum uteri, and the sound. Shocked as their English feelings are by the indelicate and indiscriminate exposure of the person in the Parisian Hospitals, and the roughness of the treatment adopted, they should distinguish the use from the abuse, and consider that such unwarrantable proceedings are not necessary concomitants of the

practice. But so long as clinical wards, devoted exclusively to the diseases of women, and under the arrangement and complete control of the professor of midwifery and physician accoucheur, are not thought necessary, or not established, clinical instruction in uterine disease cannot be efficiently given. In vain does the professor give the most lucid and natural descriptions of the diseases of the female in the lecture room,—in vain does the student ransack libraries and museums for descriptions and specimens of uterine and ovarian disease, if he has not the opportunity of investigating for himself, under the guidance of his professor, those difficult diseases—difficult I say, for whilst physiology and pathology have thrown a flood of light on diseases of the brain and nervous system; whilst auscultation and percussion have rendered the diagnosis of diseases of the chest comparatively certain, and the microscope, in revealing the minute structure of the liver and kidneys, and enabling us to distinguish the most minute changes in their excretions, has vastly improved our knowledge of hepatic and renal maladies, our knowledge of the nature, diagnosis, and treatment of uterine diseases remained till within the last few years almost stationary.

The last few years, indeed, have witnessed the establishment of clinical wards, devoted exclusively to diseases of women, in several of the larger hospitals, and a hospital has been established expressly for this purpose, which, though small in its beginning, may hereafter rival the great Continental hospitals, and has already contributed not a little to advance our knowledge of these obscure diseases. In these institutions the more advanced students have the opportunity of tracing the course, and watching the treatment of uterine diseases, far more satisfactorily than they can do in the care of out-patients, where both women and children are seen together, and where their numbers almost preclude the physician from giving that individual attention and examination which he would wish.

I trust that, though under present circumstances it is hardly possible any such plan as I have alluded to would be adopted, yet we may hope that in the plan for the new hospital connected with this College, the importance of such an arrangement will not be overlooked; then will the school of King's College, perfect in its arrangements for practical instruction, as well as eminent for the learning and eloquence of its professors, and the noble spirit which animates them, reach that eminence which, but for the deficiency of its hospital, it would long since have attained, as the first of the metropolitan medical schools.

Having myself enjoyed the advantage of holding the appointment of House Surgeon to the Hospital for Women for nine months, and subsequently that of House Physician to King's College Hospital, I have had unusual opportunities of studying uterine diseases, and have for this reason selected one of the many forms of

displacement of the uterus for consideration this evening, not only on account of its intrinsic importance, but because it enables me to introduce to the notice of the Society some great improvements in the diagnosis and treatment of the maladies of this organ.

Till within the last few years very little was known of the displacement of the womb, denominated *retroflexion*. We find in authors very vague notices of it, as a pure and interesting affection. Dr. Denman is the first author who speaks of it in his treatise on Midwifery and Diseases of Women. After more particularly describing retroversion of the uterus, as it occurs in the pregnant state, which is a perfectly distinct affection from that under consideration, he says,—“The retroversion of the uterus has generally occurred about the third month of pregnancy, and sometimes after delivery; it may likewise happen when the uterus is from any cause enlarged to the size it acquires about the third month of pregnancy, but not with such facility as in the pregnant state, because the enlargement is then chiefly at the fundus. If the uterus is but little enlarged, or if it is enlarged beyond a certain size, it cannot well be retroverted; for in the first case, should the cause of a retroversion exist, the weight at the fundus would be wanting to produce it, and in the latter the uterus would be raised above the projection of the sacrum, supported by the same. Another complaint similar to that which we have been describing, and which has been called a *retroflexion*, has occurred in practice. By this term is implied such an alteration in the position of the parts of the uterus, that the fundus is turned downwards and backwards between the rectum and vagina, whilst the os uteri remains in its natural situation, an alteration which can only be produced by the curvature or bending of the uterus in the middle, and in one particular state,—i.e., before it is properly contracted after delivery. A retention of urine existing at the time of delivery, and continuing unrelieved afterwards, was the cause of the retroflexion in the single case of that kind of which I have been informed by Dr. Thomas Cooper, and the symptoms were like those occasioned by the retroversion. When the urine was drawn off by the catheter, which was introduced without difficulty, the fundus of the uterus was easily replaced by raising it above the projection of the sacrum, in the manner advised in the retroversion, and it occasioned no further trouble.”

The following historical notice was published by Madame Boivin, in her “*Traité Pratique des Maladies de l'Uterus et de ses Annexes*.” “Dr. Denman's case was nearly forgotten, when an observation, forwarded by Madame Boivin to M. Ameline, and published by that gentleman in his thesis on ‘*Anteversio*,’ fixed the attention of practitioners of midwifery; since that time incurvations of the unimpregnated uterus have been often recognized, and rationally treated. We here purposely make use of the epithet unimpregnated, to distinguish deflexions of the uterus in that state from an inclination of the same organ during advanced pregnancy, which was known before. Baudelocque had correctly observed, that in certain obliquities of the

uterus, the neck deviated from the natural axis of the entire organ, in the same direction as the fundus. The same fact has been observed by Madame Lachapelle, Velpeau, and others."

Dr. Moreau, of Paris, is the only observer who notices the fact of retroflexion occurring more frequently in the unimpregnated state, than during pregnancy. Professor Tiedemann, of Heidelberg, published in 1840, some researches on what he designated the *congenital obliquity of the uterus*, an obliquity depending on an inequality of the broad ligaments by which its fundus is bound down to one side of the pelvis.

Seeing this displacement was but little known, we shall not wonder when we find the records of its detection after death to be few.

Saxtorph, in his "*Animadversiones de correctione Uteri et Fœtus, in partu*," says, "In a body which I opened some time ago, in the presence of the first medical men of this place, I found a virgin uterus, the fundus of which, as a congenital formation, was completely bent backwards, and which if it had even been impregnated, would on account of its faulty structure, have probably been unequally distended, and have become oblique." Dr. Rigby observes, in reference to this quotation, "The fact is interesting, but the inference about the obliquity of the uterus is wrong, the old theory on this subject, promulgated by Deventer at the beginning of the last century, having been long since proved to be incorrect."

Jahn, a German physician, in examining the body of a girl aged 14, in whom the hymen was uninjured, found the uterus bent to the right side, in the shape of a retort; the cervix uteri, which rose straight from the vagina, took a sharp turn to the right, so that the obliquely-formed fundus lay in the upper and right part of the pelvic cavity; at the point where the curvature took place, the os uteri internum, viz., the upper part of the canal of the cervix uteri, was so contracted that it would not even admit the finest probe. The os uteri externum was of the natural shape, and formed a transverse fissure.

Schreger gives the case of a young woman, aged 20, who died of consumption, and in whom the uterus was found retroflected, the fundus being turned back to the hollow of the sacrum, and to the right. The direction of the urethra was natural, and the patient had never complained of any difficulty in passing her water; she had also menstruated regularly up to the last stage of her illness.

Dr. Simpson, of Edinburgh, has for some years been carrying on his researches on this subject.* In 1844 Dr. Protheroe Smith first made out the existence of this displacement in a patient at the Hospital for Women; and since that time, both Dr. Protheroe Smith and Dr. Rigby have met with numerous cases in practice, and have proved that the disease is of far more frequent occurrence than is generally supposed,

and much more frequent in the unimpregnated state, than retroversion in the pregnant.

How is it then, we may inquire, that a disease so frequent in occurrence, and so important in its consequences, has been so long overlooked or unrecognized? It arises from the defective means of diagnosis. Even in 1836, Dr. Davis, in his elaborate work on "*Obstetric Medicine*," very truly asks in reference to the diagnosis of deflexion of the uterus:—

"Does the supposed palpable doubling of the angle of flexion by the finger furnish sufficient evidence to the practitioner of the continuousness and identity of the tissues forming its two sides? If not, it should of course follow that the tumour, supposed to be the fundus of the deflected uterus, might really prove to be one of morbid growth, either from the body of that viscus itself, or from any other part or organ in the neighbourhood. Hence the diagnosis of these deflexions, when of long standing, and become actually chronic in their essential character, must always, in the author's apprehension, present a subject of considerable doubt and difficulty." Dr. Davis having no other means of diagnosis, it is no wonder that he should arrive at the very erroneous conclusion that retroflexion of the uterus was a very rare occurrence.

Dr. Simpson, in introducing his instrument (the uterine sound,) laid down the four following propositions, the truth of which is so obvious, that I deem it unnecessary to enter into further proofs respecting them.

"1. The general and local functional symptoms of disease of the uterus are such as enable us to localize, without enabling us to specialize, the exact existing affection of the organ.

"2. In almost all instances of diseases of the uterus, it is only by the physical examination of the organ itself, that we can distinguish the precise nature of the existing affection, and fix its character, extent, &c.

"3. The physical examination as formerly practised, seldom enables us to ascertain accurately the organic condition of more than the cervix and lower part of the body of the uterus.

"4. It is possible, by the use of a rod or bougie, introduced into the uterine cavity, to ascertain the exact position and direction of the body and fundus of the organ, to bring these higher parts of the uterus in most instances within the reach of tactile examination, and to ascertain various important circumstances regarding the os, cavity, lining membrane, and wall of the uterus."

The bougie proposed by Professor Simpson, and called by him the *Uterine Sound*, is an instrument provided with a flat handle, having one surface roughened,—that corresponding to the concavity of the instrument. Its shaft is about nine inches long, and terminated by a roundish bulb, about one-eighth of an inch in diameter; the shaft is composed of flexible metal, to enable us to alter its curvatures; it gradually tapers in its thickest part; it is about one-fifth of an inch in diameter, corresponding in size to No. 8 silver catheter; in its thinnest about one-tenth of an inch,

* Dr. Rigby has also published some papers on this subject in the 13th Vol. of the *Medical Times*.

in size, corresponding to No. 3 catheter. This instrument is graduated and marked at two and a half inches from the bulb, by a projection on the convex surface of the curve, to enable the finger to judge of its having passed to its full extent. The natural length of the cavity of the uterus is two and a half inches, and it forms a slight curvature forwards and upwards. The sound is passed with greater ease than the catheter, and produces less uneasiness than that instrument, certainly much less than the passage of a catheter in the male subject. The mode of passing it is as follows:—The patient is placed on the left side, with the knees drawn up; the forefinger of the left hand is then introduced to find the os uteri; having done so, the sound is passed, held lightly between the finger and thumb of the right hand, along the forefinger, and guided by it, is insinuated into the os, and gradually and gently pushed along the cervix into the cavity of the uterus; in some cases the canal of the cervix or the os internum is so small as not to allow it to pass, it must then be first dilated.

The application of the uterine sound has opened a new era in the history of uterine diseases; by its means, cases before imagined to be malignant affections of the os and cervix uteri have been proved to be nothing more than extreme congestion, produced by retroflexion of the fundus,—long standing affections pronounced by eminent men to be incurable; fibrous tumours have been demonstrated to be retroflexions, and removed by restoring the fundus to its natural situation; whilst other tumours, of whose connections it was difficult if not impossible to be certain, have been shewn to be ovarian and unconnected with the uterus. But time will not permit me to enter into the numerous applications and uses of the uterine sound.

We must now proceed to inquire what are the symptoms produced by this displacement, and the causes which lead to it?

In some cases no appreciable symptoms are produced, except perhaps a greater flow of the menses, and a greater tendency to abortion in the married female, whilst in others the symptoms are exceedingly distressing and complicated. It is in most cases difficult to trace the first origin of the affection, but in some instances in which diligent enquiry has succeeded in doing so, the patient would appear to have been cognizant of some depression or falling down of the body of the womb, sometimes occurring suddenly, in other instances more gradually progressing, in the former producing alarming sympathetic affections, as nausea and vomiting, and actual syncope, together with more or less pain referred to the groin or sacrum. The retroflexion increasing or becoming permanent, produces some pain and difficulty, or frequency in micturition, though it never leads mechanically to retention of urine. The patients complain likewise of a dull aching constant pain in the sacral region, probably

arising from the pressure of the fundus on the sacral nerves, since it is often immediately removed on raising the fundus; the pain often shoots down one of the thighs, there is also a sense of weight and bearing down towards the rectum, much increased by the act of defæcation. Advice not being sought at this period, or the displacement being overlooked, other more serious symptoms manifest themselves; menstruation becomes highly painful, the discharge is generally increased in quantity, and clots and shreds denoting irritation are voided,—in short, dysmenorrhœa is set up. In the intervals an abundant leucorrhœal discharge is usually present.* These symptoms cannot exist without the patient's general health suffering more or less; the stomach, which has an intimate sympathy with the womb, becomes disordered, the appetite is capricious and irregular, the tongue loaded, the bowels constipated, the patient's spirits are depressed and irritable, and a variety of nervous hysterical affections are apt to occur. Such symptoms as these, though they do not prove the existence of a displacement of the womb, yet evidently localize the affection there, and warrant further examination per vaginam, which alone can enable us to determine with certainty the existence of this displacement, and to rectify it.

In examining a case of retroflexion of the uterus during life, the finger can frequently reach a firm globular mass, situated behind the cervix uteri, between the rectum and vagina; this is the fundus uteri, which is bent downwards and backwards, the os uteri instead of being forcibly dragged upwards and forwards behind the symphysis pubis as in retroversion, is little, if at all, removed from its natural situation. At first we may not be able to determine this globular mass to be connected with the uterus at all; it may appear to be merely a scybalous collection in the rectum, hence we should always if possible, before examining a patient, prescribe an aperient or an enema to remove this source of error. In other cases the tumour may be too high up to allow the finger to trace its continuity with the cervix, whilst in others again, the point of curvature being low down, the fundus is much below the os uteri, and its continuity is easily traced by the experienced finger.

The exact position of the retroflexion varies considerably in different individuals, and even in the same individual, at different times; the point of curvature may be so high up that a very small portion of the fundus is all that is bent down. On examination per rectum we feel the same globular mass through the anterior wall of the intestine, and being able to reach much higher up in this direction than per vaginam, we can frequently verify or correct our first impression.

* In cases immediately following abortion, reproduced by a too early recurrence to ordinary occupations or undue exertions, I have observed the hæmorrhage to continue a longer time than usual, and even become constant.

It is, however, by the use of the uterine sound, that we can obtain sure and valuable information of the displacement of the womb. In a case of retroflexion, on passing the instrument in the natural direction upwards and forwards, it becomes almost immediately arrested; but on turning its point in the contrary direction, backwards and downwards, it will pass readily along the cervix uteri, and then glide downwards and backwards to its full extent of two inches and a half. The point can now be felt distinctly in the centre of the tumour, through the posterior wall of the vagina, or the anterior of the rectum, thus proving it to be the fundus uteri in this unnatural position. Nor is this all, by turning the instrument gradually and gently round, so as to bring the point upwards and forwards, at the same time assisting the elevation of the fundus with the forefinger of the left hand, we shall find that the tumour disappears, it can no longer be felt, the fundus is restored to its natural situation, and retained there by the sound without it; the patient will often be immediately relieved from the constant pain and uneasiness from which she has previously suffered in the sacral region.

In some instances the mere restoration of the fundus to its position is sufficient; it remains there permanently, even after the withdrawal of the sound; in others for a short time only; but in many cases, especially in those of old standing, the disposition of the fundus to return to its unnatural position is so great, that it requires the handle of the sound to be held pretty firmly to prevent its turning it round, and as soon as the sound is withdrawn, the fundus again retroflexes, and we can again trace the tumour as before.

The examination and passage of the sound produces in many instances little or no pain, until we elevate the fundus, when the instrument, pressing on the ovary, which we shall afterward see is extremely apt to become congested and inflamed in consequence of the displacement, occasions severe pain, which, however, immediately ceases on our completing the restoration. In the examination per rectum the pressure of the finger on the fundus above occasions no pain, but if we elevate it, the patient immediately complains, and by passing the finger beyond the depressed fundus, we can discover the exact seat of pain to be the posterior and upper part of the fundus, in the situation of the ovary, which we can often feel as an oval body. These last symptoms are dependent on the inflammation of the ovary, and cannot, therefore, be regarded as essential to retroflexion of the uterus, but as the consequence of a complication. It occurs, however, sufficiently often, to render it advisable in all cases of oophoritis of long standing, to examine carefully into the position of the uterus.

In some cases the canal of the cervix is so small as to prevent the passage of the sound: in such a case the dilator must first be employed, until a sufficient passage

has been obtained. Dr. Rigby is of opinion that this extreme narrowness of the cervix is rather owing to a congenital formation than to the bent state of the fundus, which last, however, he regards as sufficient not only to obstruct the free discharge of the catamenia, but to prevent conception.

I will here introduce to the notice of the Society the dilator which I am in the habit of employing, and which I believe to be the most efficient; it is that invented by Dr. Protheroe Smith. The power of the screw is the moving power, and it is capable of being regulated at the pleasure of the operator. After one or two dilatations we shall be able to pass the sound through the cervix, and ascertain the state of the fundus.

If any of you are still sceptical of the benefits to be derived from the employment of the sound, let me quote a passage from a paper read by Professor Simpson before the Dublin Obstetrical Society, shortly after he proposed his instrument to the profession,—he says, “In one of the first cases in which I recognized by the uterine bougie, the existence of retroflexion of the unimpregnated uterus, the patient had some years previously been doomed by the highest obstetric and pathological authorities in England, as suffering under the first stage of scirrhus uteri, the displaced fundus having been mistaken for a carcinomatous tumour. The uterine displacement was easily rectified by the use of a wire pessary, worn for some months in the uterine cavity, and the patient is now in the enjoyment of the best of health. I have seen other cases of the same mistake with the same curious but common form of uterine displacement.”

It was only the other day that my friend, Dr. Protheroe Smith, informed me, that several cases, which had been sent to him as cases of fibrous tumour of the womb, had proved on examination, nothing more than retroflexions. The celebrated case of Miss Martineau, which attracted so much attention in the literary world, and which was afterwards published by her medical attendant, Mr. Greenhow, of Newcastle, was an instance of retroflexion of the womb, complicated with a small polypus growing from the interior, and inflammation of the left ovary; the enlargement of the body and fundus was the effect of the displacement. Had the true nature of the malady been detected in the first instance, and the fundus restored to its position by the sound after the removal of the polypus, the talented sufferer would have been spared many years of suffering and useless drugging. The ultimate and gradual restoration of the organ to its normal situation, which took place after the bowels had been unloaded, and the general health improved by purgatives, and which occasioned the patient's restoration to health and to society, would not then have been attributed to the Mesmeric influence.

(To be continued.)