FIXED RETRODEVIATION OF THE UTERUS.

WITH SPECIAL REFERENCE TO TREATMENT.

by

E. ARTHUR GIBSON, M.B., C.M.

INTRODUCTION:

On beginning work as Gynaecologist to the Bellahouston Dispensary of the Victoria Infirmary I was impressed by the necessity for a treatment which would give some hope of cure in cases of Fixed Retrodeviation of the Uterus. The majority of these Cases were unable, on account of their domestic and other duties, to go into Hospital to have an operation performed, and as a matter of fact all were adverse to operative interference, so the question to be solved was, what could be done for them as out-patients coming twice a week or so? Even minor operative interference such as Curettage, I do not consider safe at an out-patient department, and the treatment of either Schultze or Thuré Brandt, for reasons I state further on, I could not adopt. After thinking the matter over I arrived at the conclusion that a modification of Schultze's method would be of service, and this I adopted with the results embodied in this thesis. What I claim for this method is, not that it is a panacea for all cases of Fixed Retrodeviation; but that it is a method, which, if properly carried out, will effect a cure in the vast majority of cases. It is further peculiarly suitable for an out-patient department and for Patients who refuse operation, and it is quite free from danger.

I have used the term Retrodeviation to include both Retroversion and Retroflection, as whatever the Pathology of these affections may be the treatment in these cases was the same.

I have thought it wise, for the sake of completeness, to give a short resumé of the Anatomy of the Uterus, and the other organs involved before discussing the Pathological conditions.

A N A T O M Y.

The Uterus is a hollow muscular organ, situated in the pelvic cavity between the rectum and bladder. In the virgin it is generally stated as measuring 7.5 centimetres in length, 5 centimetres, in breadth, at its broadest part, and 2·5 C.M. in thickness. It is described as consisting of a Fundus, Body and Cervix. The Fundus is that upper convex part of the body which projects above the level of the Fallopian Tubes. The Body is that part which narrows as it descends to a constriction in its cavity called the Os Uteri Internum. It measures 5 c.m. in length. The remaining 2.5 c.m. ending in the Os Uteri Externum is termed the Cervix. The Uterus is flattened from before backwards; but its posterior surface is much more convex than its anterior. The cavity is triangular in shape with the base directed upwards. Owing to the antero-posterior flattening of the Uterus the anterior and posterior walls of the cavity are in contact. The cavity is divided by the above mentioned Os Internum into the cavity of the Body, and that of the Cervix. It may be mentioned that the cavity is lined by a mucous membrane which in the Body is smooth; but in the

Cervix is firm and marked by folds called the Arbor Vitae.

The Fallopian Tubes are two in number and pass out in the upper margin of the Broad Ligament from the Right and Left upper angles of the Uterus in an almost horizontal direction until they reach the side walls of the Pelvis against which they ascend in front of the corresponding Ovaries, and then arch backwards above these glands and internal to their Suspensory Ligaments. Finally they turn downwards so that the Fimbriae are opposite the inner surfaces and posterior borders of the Ovaries. Each tube is about 10 cm. in length and its structure is similar to, and continuous with that of the Uterus. The cavity of the Tube, which is continuous with that of the Uterus, will, at its narrowest part, hardly admit a hog's bristle. At the outer end the Tube widens into the Ampulla and ends in a number of Fimbriae, the so-called Fimbriated Extremity.

The Ovaries are two somewhat flattened Oval Bodies which lie projecting from the Posterior Lamina of the Broad Ligament and on the side walls of the Pelvis. They usually measure 36 M.M. in length, 18 M.M. in breadth, and 12 M.M. in thickness. As regards their position the following may be quoted from Quain's Anatomy:- "The exact "position of the Ovary is by no means uniform, and opinions "are divided as to the conditions which may be regarded as

"normal. According to His, Waldeyer, and the majority of "recent observers, the Ovary in the nullipara is placed "against the side wall of the Pelvis with its long axis "vertical in the erect position of the Body". It is only attached to the Broad Ligament by its Anterior Border, the others being free. "To its upper extremity is attached the "Ovarian Fimbria of the Fallopian Tube, and also a Perito- "neal fold, the Ligamentum Infundibulo-pelvicum, which "passes downwards from the brim of the pelvis and con- "tains the Ovarian vessels and nerves. The lower end of "the Ovary is attached to the Uterus by the Ligament of the "Ovary. This extremity does not normally reach the floor of "the pelvis so that the Ovary is suspended against the "side wall of the pelvis." +

+ "Quain's Anatomy," Last Edition.

PELVIC PERITONEUM & LIGAMENTS OF UTERUS:

The Parietal Peritoneum is reflected on to the Bladder a little above the level of the Pubis, and passes on to the Uterus at the level of the Os Internum thus forming the Vesico-Uterine Pouch. Thence it passes over the fundus and down the posterior surface of Uterus which it completely covers together with the uppermost half inch of the Vagina. It is then reflected on to the Sacrum and Rectum. The piece of Peritoneum which passes from the Posterior Vaginal to the Anterior Rectal wall is called the Recto-Vaginal Ligament. The Cavity between the Rectum and the Posterior Uterine surface and the upper part of the Vagina is called the Pouch of Douglas. The sides of this Pouch are bounded by two semi-lunar peritoneal folds which pass from the cervix uteri in front to the 2nd. and 3rd. Sacral Vertebrae. They are called the Utero-Sacral Ligaments and contain both fibrous and non-striped muscular tissue.

The Broad Ligaments are formed on either side by a double layer of Peritoneum passing out from the sides of the Uterus to the corresponding Pelvic Wall. The Anterior layer is continuous with the Anterior, and the

Posterior with the Posterior layer of the Uterine Peritoneum. Between these layers are the Round Ligaments which pass out from the Uterus at the origin of the Fallopian Tubes and then pass forwards and outwards to the Inguinal Canal through which they pass and get lost in the tissue of the Mons Veneris. They contain both striped and unstriped Muscular Fibres.

The Fallopian Tubes run along the top of the Broad Ligaments, and the Ovaries are also seen to project from its Posterior layer. The Parovarium also lies between the layers of the Broad Ligament near the Ampulla of the Fallopian Tube.

THE PELVIC CONNECTIVE TISSUE is very abundant. It packs all the interstices between the main organs. In it run the Lymphatics, Vessels, and Nerves. "Although the Pelvic "Connective Tissue is practically continuous and passes "up to the Iliac Fossae and abdominal Cavity, it is con- "venient to recognise it as being present in the following "situations:-

(a) Round the Cervix Uteri; this is the Parametric Tissue proper of Virchow.

(b) Between the Broad Ligament;

(c) Between the Posterior Bladder Wall and Cervix Uteri;

(d) Between the Vagina and Anterior Rectal Wall;

(e) Between the Bladder and Pubis;

(f) In the Ischio-Rectal Fossa and below the Peritoneum." ÷

÷ Allbutt & Playfair's System of Gynaecology, 1896.

THE LYMPHATICS OF THE UTERUS; begin as cleft like spaces in the Mucous Membrane. There are also spaces and vessels between the Muscular Fibres which are continuous with these. These then pass into large tubes in the Broad Ligaments. Concerning the Lymphatics of the Ovaries and Tubes the following may be quoted from Pozzi's Treatise on Gynaecology; "There are superficial Lymphatics at the angles of the Uterus which are lost in the Broad Ligaments behind and below the Tubes, between the Tube and the Round Ligament and especially below the Ovary and Tube. There are also deep Lymphatics which can be demonstrated only by making a longitudinal section of the Uterine Angle; here a group of Lymphatics is situated in the hollow between the Tube and the Ovarian Ligament. Thus important communications are established between the Ovaries and Tubes which have a close anatomical connection ..... The Vessels from the Ampulla follow the Broad Ligament to the outer side of the Ovary and join the larger Lymphatic net-work called the Subovarian Plexus ..... Adhesions which are rich in Lymphatics may also transmit Inflammation. Again the net-work of Lymphatics which covers the surface of the Ovary cummunicates with the Lymphatics of the Peritoneum." †

† Pozzi's Treatise on Gynaecology. American Translation.

THE BLOOD SUPPLY OF THE UTERUS; is derived from the Ovarian and Uterine Arteries.

The Ovarian Arteries are Branches of the Aorta. On arriving at the margin of the Pelvis each Artery passes inwards between the layers of the Broad Ligament to be distributed to the Ovary. Branches are given off to the Tube and Round Ligament, and a large Branch passes down the side of the Uterus to anastomose with the Uterine Artery

The Uterine Artery is a branch of the Internal Iliac. It passes downwards and inwards to the Cervix (to which a Branch is given off). It then passes up along the sides of the Uterus between the layers of the Broad Ligament in a tortuous course distributing branches to that organ and anastomosing with the above mentioned branch of the Ovarian near its termination.

The veins correspond with the Arteries and form anastomosing plexuses.

The Uterine Plexus is situated along the sides and superior angle of the Uterus between the layers of the Broad Ligaments receiving the large Venous Canals from the substance of the Uterus.

The Ovarian Plexus is situated near the Ovary.

There is another plexus on the Fallopian Tubes. All these communicate freely with one another and with the Uterine Plexus. Finally the Uterine veins open into the Ovarian veins. The Right Ovarian Vein joins the Inferior Vena Cava, the left the Renal Vein.

THE NORMAL POSITION OF THE UTERUS: If we examine bimanually in the dorsal position, a woman whose bladder and rectum are empty, we find the vaginal portion of the cervix pointing downwards and very decidedly backwards towards the hollow of the Sacrum, while the hand on the abdomen feels the fundus lying above the Pubis. Thus the Uterus is in a state of Anteversion. It has been shewn by the investigations of B.S.Schultze that the Uterus is also Ante-flexed i.e.,that there is a distinct angle found between the Cervix and the Corpus. Now if we distend the bladder with fluid e.g.,as in washing out the bladder, and examine again, we find the fundus has risen upwards and backwards and approaches the Promontory of the Sacrum i.e., becomes retroposed. If we allow the fluid to escape from the Bladder the Uterus again follows the Posterior Bladder wall, and becomes Anteverted. Thus the normal position of the Uterus is not a fixed position, but varies with the fullness of the Bladder. Variations of position are also caused by the distension and evacuation of the rectum. If the Bladder is empty and the rectum full the vaginal portion is pushed forward, and thus the Uterus is made more anteflexed. If, however, the Bladder is distended this cannot occur and the Uterus is erected and elevated. (Schultze).

These movements are regulated chiefly by the Round and Uterosacral Ligaments although the various other Ligaments share in the work. The Round Ligaments tend to pull the body of the Uterus forward and so prevent the Fundus passing below the Sacral Promontory. The Utero sacral Ligaments pull the cervix upwards and backwards and so help to the same result. The Vaginal column supports the Uterus and it is notorious how quickly displacements occur when this is destroyed by the Perineum being torn. Other factors are the weight of the Uterus itself, and the Intra abdominal pressure. The lateral movements of the uterus are limited to a great extent by the Broad Ligaments, although by pressing on one side of Vaginal Portion a certain amount of Lateral Movement of the whole Uterus can be brought about. Schultze also asserts that the Uterine axis is somewhat twisted so as to turn the Anterior surface to the Right.

Under normal conditions the Fallopian Tubes and Ovaries follow the movements of the Uterus.

A E T I O L O G Y:

The causation of Fixed Retrodeviation of the Uterus, as far as it is illustrated by the appended cases, may be broadly stated to be chronic Inflammation of the Uterus itself or of its appendages or of both combined. Of these 17 cases, seven dated their illness from abortion, four from labour, and three gave a tolerably clear history of Gonorrhoea. In three the history was not clear as to causation. The cases in which the illness occurred after abortion or labour may be considered together as the conditions are practically the same. In the Cases where we have a history of Rigors and Fever after labour and severe illness we have no choice but to look upon the case as one where infection occurred at labour. In other cases where the history is not definite but only a statement of "never been well since", we must remember that both normal labour and abortion leave the Uterus in a state of enlargement and congestion which requirespecial care for their removal. In the class of people from whom these cases were taken this is generally conspicuous by its absence, it being

no uncommon thing for these women to be out of bed in 3 or 4 days after labour and even in a shorter time after an abortion. In these cases we have the woman going about with an enlarged uterus in which the blood vessels and Lymphatics are much enlarged, the surface of the Endometrium where the Placental site was, still unhealed, and there is a copious discharge which proves a fruitful culture medium for microbes. Thus we are liable to have the Uterus infected even after labour more especially if there has been a laceration of the Cervix or Perineum. The path of infection is generally stated as beginning in the Uterine Mucous Membrane where it sets up an Endometritis which goes on to involve the muscular walls of the Uterus both by means of the Lymphatics and by contiguity of tissue. At the same time the inflammation passes up by continuity of tissue to the Fallopian Tubes which become involved. In connection with the further development of the case the following may be quoted from Pozzi "Aran, may be said to have anticipated his generation by attributing pelvic peritonitis to inflammation of the Uterine appendages. He clearly shews that these are the foci around which

gather pus and false membranes..... At the present time the tendency is to return to Aran's views; but in my opinion there is not enough emphasis laid upon this theory as the only possible solution of all periuterine inflammation. The more recent writers still give a separate description of parametritis and perimetritis to which they sometimes add Adenolymphitis with the result that the bewildered reader can scarcely follow the subtilties of diagnosis. For my part I frankly acknowledge that I believe in Aran's theory. The facts which I have personally observed have shewn me that nearly all peri-and parametritic inflammation are merely forms of Salpingitis and Peri-salpingitis"†

Another proof that the inflammation has proceeded from the tube itself and not from the Uterus by way of the lymphatics is that it is rare to find traces of Inflammation on the Anterior surface of the Broad Ligaments. Such traces are almost universally found on the Posterior Surface between the Ligament and the sacrum; this would seem to be accounted for by the position of the tube and Ovary on the Posterior Surface of the Broad Ligament.

† Pozzi's treatise on Gynaecology, American Translation.

In "An American Text Book of Gynaecology" the path of infection is thus stated; "as the infection extends from the Uterus it spreads at once along the Mucous Membrane of the Fallopian Tube out of its fimbriated opening directly to the Ovary and into the Pelvic Peritoneum."

The Ligaments of the Uterus during the puerperium and after an abortion are infiltrated and soft, and normally involution should take place in them as well as in the Uterus itself; but if the conditions depicted above are brought about they share in the inflammation produced, and are unable to perform their function. Therefore the position of the Uterus is to a considerable degree dependent on the abdominal viscera. As the bladder fills it pushes it upwards and backwards where being little influenced by the toneless ligaments it may pass below the promontory of the Sacrum, and thus a Retroversion is brought about. Adhesions form from the perimetritis, and the Uterus becomes more or less firmly fixed in its abnormal position. As regards the production of Retroflection E.Martin attributes it to

the subinvolution of the Anterior Surface of the Uterus where the Placenta has been inserted. "Considerable importance must also be attributed to the weight of the enlarged organ and to the relaxation of the Broad and Round Ligaments which cease to hold the body of the Uterus in position while the Cervix remains fixed by the more resisting Utero-Sacral Ligaments". (Pozzi)

In a large number of these Cases (6 out of the 17) the Uterus was not only Retrodeviated but especially so to one side, with one exception this being always to the right side. A very evident explanation of this is the well known contraction of old Fibrous Tissue which would draw the Uterus to the side on which these adhesions were most numerous and strongest. But other factors also play an important role. These women almost invariably suffer from constipation with the consequent habitual over distension of the rectum which not only keeps a Retrodeviated uterus in its abnormal position but pushes it to the right side. Again we have the uterus normally more on the right side than on the left; but in these cases this has only a minor influence.

Gonorrhoea has long been recognised as a fruitful source of pelvic inflammation. The infection passes from the Vagina to the Uterus where it sets up a Gonorrhoeal Endometritis and the Tubes and Pelvic peritoneum and cellular tissue are involved in the same way as in puerperal sepsis described above. In these cases we have not got the large Puerperal Uterus at the outset; but the Metritis which follows always enlarges the Uterus to a certain extent. The Ligaments also lose their tone from the inflammation. In case 13 the commencement of the illness was admittedly Gonorrhoea. The proportion of Cases caused by Gonorrhoea to that following on labour and abortion in the appended list is very small; but the number of Cases is not large enough to allow of any comparison. Again we must remember that the abortions may have been caused by an old Gonorrhoeal Endometritis, and ~~(that)~~ the subsequent illness may thus have been Gonorrhoeal in origin; also that in the Puerperal cases the patient may have been suffering from Gonorrhoea at labour, and that the cause of the subsequent illness was the Gonococcus. When these points are considered it will be seen what an important

factor Gonorrhoea is in the causation of pelvic inflammation and thus of Fixed Retrodeviation.

The Cases for which no definite cause can be assigned are Nos.8,15,& 16 in the appended List. These three women were all multiparae and had suffered from the Uterine Syndroma "for years". All suffered from marked constipation. Two of them had aborted; one three times before she had a living child, although I could make out no further evidence of Syphilis. They were all very stupid women and showed a marked reluctance to give a definite history. Though we cannot state definitely the cause in these cases I think we may infer the one to be due to Syphilis and class the other two under what Auvard terms "Insidious cases of septic infection"†

Schultze, considers that constipation plays a part in the causation of pelvic inflammation. He writes:- "In my opinion habitual distension of the rectum and bladder may not only lead to relaxation of the means of attachment of the Uterus but may even cause chronic inflammation in the peritoneal folds which pass on to the Uterus". x All these patients,

† Traite practique de Gynecologie, par Auvard, 1892.
x Schultze's Displacements of the Uterus, translated by Macan.

with two exceptions, complained of marked constipation, but on inquiring more fully into this it was often discovered that they avoided defeacation as much as possible on account of the pain caused thereby; thus if not causing the constipation at least increasing it by their carelessness. Although I at once recognise the fact that a loaded rectum aggravates a Retrodeviation when once produced, I am not prepared to admit that it causes perimetritis and thus fixed Retrodeviation; in a word I look upon it as much as an effect as a cause.

In the appended Cases although the Cervices had generally some lacerations, as seen in almost every Multipara, there were none in which there was any marked laceration, and in none was there a Ruptured Perineum so that these factors may be dismissed as causes, at least as far as this paper is concerned.

Subinvolution as a cause of Retrodeviation need not be dwelt upon as it itself is very frequently brought about by a septic or specific infection of the Uterine cavity in the puerperal woman and this has been considered under septic causation. Another cause of Subinvolution is the patient rising too soon, and as I

have already stated this is very common among the poorer classes,I myself having known of a case where the woman was up attending to her household duties on the second day after labour. It is very questionable if a non-septic Subinvolution could produce a Fixed Retro-deviation such as we are considering, although I recognise it as a fruitful cause of non-complicated Retroversion and Retroflection.

P A T H O L O G Y:

At the outset I wish to state definitely that I am only considering the Pathology of Fixed Retrodeviation of the Uterus, and that Cases where the Fallopian tubes contain fluid (Hydro-Pyo-& Haemato-Salpinx) or where the inflammation has gone on to the formation of a pelvic abscess are without the scope of this paper.

As I have shewn above the causation ~~for~~ of Fixed Retrodeviation of the Uterus is inflammatory in origin in so far as it is exemplified by the appended Cases. The inflammation starts as an Endometritis and we have the Endometrium hypertrophied with its vessels and lymph spaces enlarged. The muscular tissue of the Uterus is also infiltrated, and if the Case is a puerperal one or after an abortion, the normal involution is prevented. Thus the weight and size of the Uterus are both increased. The process passes up the Fallopian Tubes and so thoroughly may the Tube walls be penetrated by the inflammation that the Peritoneum covering them may become involved. If this infiltration is not absorbed

the tube will be left permamently thickened and hypertrophied. When the inflammation in the tube has proceeded to the above condition the peritoneum will have become so involved as to throw out plastic lymph which will undergo organisation and form adhesions. In certain cases this exudation will be absorbed and a perfect cure result; but not in the Cases we are considering. The Fimbriated Extremity of the Tube may become closed and adherent to the Ovary. The inflammation spreads in a majority of cases from the tube to the Peritoneal cavity either by the extension of the infection through the open tube or by subsequent emptying of a dilated tube into the Peritoneum; we then get a peritonitis which in the Cases under consideration is of a Fibrinous Form. In this Case should two surfaces come together they will adhere, and, unless resolution and absorption take place, they remain fixed by adhesions which are more or less dense and well organised according to the original amount of lymph poured out, and the activity of the serous membrane. It has been shown above that the adhesions are generally on the posterior surface of the Broad

Ligament due to the infection proceeding from the Fallopian Tubes. Thus the parts most directly involved are the posterior surface of the Uterus and the peritoneum covering the rectum and posterior pelvic wells, and should these become adherent we have a Fixed Retrodeviation of the Uterus.

In the causation of Retrodeviations, Schultze lays great stress on the involvement of the Folds of Douglas.

The inflammation may proceed further and involve the Connective Tissue. The extent to which will depend on the activity of the process. This involvement of the Connective Tissue is in a vast majority of Cases secondary to that of the Peritoneum.

Though the Fimbriated Extremity frequently becomes agglutinated and occluded, this is not always so as shewn by the Cases in which pregnancy occurred after treatment.

The Ovary is generally involved and very frequently becomes heavy and prolapsed, and may, together with the Tube and Uterus form one mass which becomes adherent

to the rectum or to the pelvic walls. It sometimes takes on a microcystic degeneration, sometimes becomes sclerosed. These facts I was able some years ago to study for myself through the kindness of Dr.Lindsay Steven, then Pathologist to the Royal Infirmary, who allowed me to examine the Pelvic organs of female Post mortem Cases. What specially struck me was the strength in some cases of the adhesions, Douglas's Pouch being frequently obliterated and the Ovaries and Tubes lying in a mass of adhesions below the Retrodeviated Uterus. In a number of Cases the Fallopian Tubes were impervious throughout their entire length. The Uterus sometimes may also form adhesions with the intestines and Omentum; but I have only once seen a case of this Post mortem. Clinically four varieties of adhesions are recognised+

1. The Spider Web adhesion. In this variety the Tubes, Ovaries and Uterus are covered with a thin layer of well organised Membrane which when held up to the light is not unlike a spider's web. This membrane, although it can easily be torn by passing the finger through it, is very difficult to break by stretching, and in doing so

+ American Text Book of Gynaecology.

the viscus to which it is adherent may be badly injured.

II. In this variety the pelvic organs get fixed in the lymph as if they were set in a bed of Plaster of Paris. The lymph organises, and from it is formed a new and apparently real peritoneal covering. To this class Cases 10 & 16 belong.

III. The "Bread and Butter Variety" so-called because when the surfaces have become separated they are rough, and look like two pieces of bread which have been stuck together with butter and then separated. These adhesions vary in strength very much according to whether the Case is acute or chronic. In chronic cases they are often very firm, so much so that in cases where the Uterus is attached to the rectum and violence applied to separate them, the rectal walls will rupture before the adhesions tear. This is a most usual form of adhesion.

IV. The fourth variety of adhesions is where the lymph going to form the above variety has become infected and so becomes more or less broken down and is correspondingly easy to deal with. This variety is only met with where

there is pus in the tubes and so does not play a role in the cases under consideration.

A glance at the above will show that the only difference between these varieties is the extent of involvement and organisation.

Another point to be remembered is the engorgement of the Uterus with blood in cases of Retrodeviation. This is due to the vicious position of the organ pressing on the veins and so impeding the return flow.

S Y M P T O M S:

These Cases presented the usual symptoms of Uterine Disease - what Pozzi conveniently terms "Uterine Syndroma" - plus the symptoms due to the displacement of the organ such as frequent micturition and painful defæcation.

I. MENSTRUATION:

(a) Menorrhagia and irregular Menstruation are the rule. The patient generally tells you that up to a certain time she menstruated regularly; but since then the periods have been irregular, and that she loses too much blood at them. If the Menorrhagia is severe there are clots discharged.

Only in one of these Cases did the patient tell me that her menstrual discharge was scanty, and the intervals between the periods longer since her illness began than formerly.

(b) Dysmenorrhoea is very commonly complained of. It commences before the flow is established, and is usually worse during the first day or so; but generally lasts during the whole period. It is of the "Congestive Variety".

II. LEUCORRHOEA:

This is a constant symptom. These patients generally tell you that they have always some discharge,

that is, if they are not menstruating they are suffering from Leucorrhoea. Although the quantity may be increased by Vaginal Leucorrhoea without doubt there is always present a Uterine Leucorrhoea in these cases.

III. PAIN:

Apart from Dysmenorrhoea pain is a most constant symptom. The two most common seats for this pain are the back and the flanks, the left flank being much more commonly complained of than the right. It is constant and dull in character but is much increased by fatigue and stooping. One is often told by a patient that when she sits down she is afraid to rise on account of the pain it causes. Jolting is especially painful, and this is often illustrated by patients telling you that they can ride in a tramway car without pain, but not in an omnibus. Accompanying this pain there is often a feeling of a foreign body in the lower pelvis, that is, the patient feels her abnormally situated uterus and with this there may be an irresistible desire to expel it, the so-called "bearing down".

IV. DYSPAREUNIA:

This is frequently complained of. The pain is

caused at the end of the act and is due to the penis impinging against the congested fundus Uteri.

V. BLADDER SYMPTOMS:

In a majority of the appended Cases these were absent; but in a few they were present. The two complained of were frequent and painful micturition.

VI. CONSTIPATION:

Although this cannot be classed as a symptom of Uterine disease yet as it was so commonly complained of, I may mention it here. As a rule these women admitted that their bowels had not been regular for long before their present illness; but all declared that since then the constipation had been much worse, and the majority complained that they were afraid to go to stool on account of the great pain caused. It is very common for these patients to have an evacuation of the bowels only once a week.

VII. DYSPEPSIA:

Dyspepsia has long been known to be caused by Uterine Disease, and in many of these cases it was marked.

The most prominent symptom was Tympanites which not only is very uncomfortable to the patient but annoying to the physician as it sometimes renders bimanual examination very difficult. In many cases it is undoubtedly due to the constipation.

VIII. NEUROSES:

As regards the various Neuroses, so elaborately described by many writers, I have nothing to say as they were present in none of these cases; but we must remember that Dispensary patients are, as a rule, not so emotional as their more favoured sisters.

D I A G N O S I S:

Although the Diagnosis may often be made by mere vaginal touch the patient should always be systematically examined by the bimanual method. For this the patient lies on her back on a couch with her knees bent and her thighs flexed and widely separated. If the bladder has not recently been emptied the urine should be drawn off with a catheter in order that an erroneous diagnosis may not be made through the Uterus being Retroposed by a distended bladder. If, on Vaginal examination, I find the rectum loaded and the Uterus in an abnormal position I order the patient a purgative and complete examination next day when the bowel is empty. This I had to do in many of these cases. Again, if the patient is very frightened, or, if examination is causing her such pain, that she contracts her abdominal muscles, I prefer rather to forego making a complete examination at the first sitting, than to hurt her much, as I find that at a second examination, if she has not been hurt at the first, she generally has got confidence, to allow a complete bimanual examination to be made,

whereas, if at the first consultation she had been caused great pain, she never afterwards regains confidence, and short of an anaesthetic, a complete exploration of the pelvis cannot be made.

By bimanual examination we find the body of the Uterus absent from its normal position behind the pubes. If the fingers in the vagina are now placed in the Posterior Fornix the generally enlarged and very often tender fundus is found there. If it be a Retroversion the Cervix looks forward; but if a Retroflection it looks backwards, and the angle of the flexion can be felt; as a rule this is not a right angle. We also are able, if the patient is not too stout, to make out the condition of the Ovaries, if they are in their normal position, or displaced below the Retrodeviated Uterus. If there has been much pelvic inflammation, with a large quantity of adhesions resulting, it is frequently very difficult, and sometimes impossible to locate the Ovaries without the patient being deeply narcotised. The fixity of the Uterus is determined by trying to displace it, by pressing on the fundus with the vaginal

fingers. In some cases you may feel the uterus lying in a mass of adhesions (Case 10). In some you may make out the tubes to be thickened, and in others the Broad Ligaments to be infiltrated.

As regards the Uterine Sound as an aid to diagnosis in these Cases I may say that I seldom use it, as one is never absolutely sure of their Asepsis at an out-patient department, and as a rule the Cases are made perfectly clear by bimanual examination. But in Cases where the Uterus is high up, and adherent to one side (e.g.,Case 5.) the Uterine Sound is of great service.

Great benefit is got by pulling on the cervix with a Volsellum, especially if a rectal examination is made at the same time. By this method of examination the adhesions can be felt, and a much more definite idea of the quantity, strength, and elasticity, be obtained than by a vaginal examination. In these cases, one can generally reach with the finger in the rectum above the displaced fundus, if at the same time the thumb is inserted into the vagina. I constantly made use of this method to confirm my diagnosis in the annexed Cases.

T R E A T M E N T:

The Treatment of Fixed Retrodeviation of the Uterus has long occupied the mind of Gynaecologists, and one has only to consider how many methods have been suggested, to be assured that none of them has been effectual. Of the various operative proceedings, I have nothing to say, as the method which I employ had to be suitable for patients attending an Out-Patient Department; but two methods I may briefly mention, first Schultze's, and secondly Thuré Brandt's.

Schultze advocated two methods:-

(a) In simple cases, the patient being deeply narcotised he introduced the index and middle fingers of the left hand into the rectum and on them elevated the fundus. With the right hand he then grasped the fundus through the abdominal wall, and endeavoured to bring it forward. In this way he broke down the adhesions;

(b) "In Cases of exceptional difficulty"; he employed what he termed "Intrauterine Reposition". "In this method the finger used internally, instead of acting on the vaginal vault or rectum, is applied to the inner side of the fundus of the previously dilated Uterus. Two fingers are introduced into the vagina and one of them pass into the retroflected Uterus as far as the fundus. This finger, and with it the Uterus, is extended, its palmar surface having then been turned towards the anterior wall of the Uterus, it is bent towards the surface of the abdomen." ÷

÷ Schultze's "Displacements of the Uterus", Translated by Macan.

After breaking down adhesions he keeps the patient for several days in bed, with an ice bag applied to the abdomen for the first 24 hours.

Undoubtedly this method or methods is very thorough but the risk, although Schultze states that he never saw any distinct signs of peritonitis following it, is great, as these adhesions in old standing cases are so organised, that in many cases they are stronger than the rectum to which they are generally adherent, so that in forcibly replacing the uterus this organ is liable to be torn. I may say that on the cadaver I have several times done so. Or if the Tubes contain any pus they are liable to be ruptured and so set up a septic peritonitis. Again the technique could not be practised at an Out-patient Department.

Thuré Brandt's method aims at avoiding pain and getting the adhesions absorbed by Massage. One or two fingers of the left hand are placed in the vagina to support the uterus, while the right hand describes circular rubbing movements on the abdominal wall above the pubes, which gradually get firmer as the muscles relax. It is claimed for this method that even in cases where the adhesions are so firm that they cannot be stretched, it causes their absorption.

The great objection of this method is the friction it applies directly to the organs of generation, as although the fingers are kept perfectly steady in the vagina, the alternate pressure and relaxation on the relaxed abdominal wall, cause the tissues, which are directly in contact with the fingers, to glide backwards and forwards over them, during the whole time the massage is performed.

The treatment which I have adopted, may be stated to be so far as the mechanical part of it is concerned, a very modified form of Schultze's method. It aims at the direct stretching of the adhesions, in so far as this can be obtained without the use of an anaesthetic, their softening and absorption by medicated tampons and douches, and the clearing out of the bowels by purgatives.

The patient lies on her back on a couch, with her shoulders slightly raised, and her hips slightly over the edge of the couch. Her knees are bent and widely separated, with her feet resting on supports. The operator stands in front of his patient with his right leg supported on a stool, and his right elbow resting on his right thigh. After preliminary douching the index and middle fingers of the right hand are inserted into the vagina and direct pressure is brought to bear on the displaced fundus. If there is much pain medicated tampons and hot douches are ordered and after

their use for a short time the pain has always disappeared, and the mechanical treatment could then be pursued.

If the adhesions are so great that no progress is made, or if the fixation is so high, that it cannot be reached from the Vagina, the middle finger is inserted into the rectum, and while the index remains in the Vagina, a Volsellum is fixed to the cervix, and pulled slightly down by the left hand. By this means, and with very little pain, direct pressure is brought to bear on any adhesions which fix the Uterus below the Promontory of the Sacrum. The sitting generally lasts about 10 minutes, and is repeated twice a week. During the intervals, the treatment consists in the application of medicated tampons and hot douches. The aim is not to tear the adhesions; but only to stretch them, and if ordinary gentleness is observed, the pain is not great, and certainly is never so severe as to require an anaesthetic. I do not apply this treatment during a menstrual period, as the patients object to it so much; but immediately after a period I do, and at that sitting the adhesions are always very soft, and the uterus can generally be freed considerably.

As regards separating the Ovaries from adhesions, I may state, that I have never been able to do so. If the Ovary and Uterus are adherent together and in Douglas's Pouch I have always found that they remain together, and are liberated as one adherent mass.

The amount of force used is not very great, and it is never applied in a jerky manner, but steadily, with the idea not to rupture the adhesions, but gradually to stretch them. If the adhesions are atretched, as a matter of course, they become both thinner and narrower, and finally, they are so small that their ruptureis a matter of no consequence. After the uterus has been so freed as to be above the Sacral Promontory, it is grasped by the left hand through the abdominal wall, as in the replacement of a non-fixed Retrodeviated Uterus, and brought forward. Of course, it is only after a good many sittings that this can be accomplished.

After each sitting a large tampon of 10% Ichthyol and Glycerine is inserted into the posterior vaginal fornix, the idea being to have it as contiguous as possible to the adhesions. After trying various medicaments I have fallen back on 10% Ichthyol in Glycerine as the best. At first I used it stronger; but Ichthyol above that strength seems to cause considerable burning pain in the vagina. The patient is directed to remove the tampon (a string is attached to it and left hanging out of the Vagina) in 24 hours. The direct action of the tampon is to cause a copious serous discharge. In other words its action is by depletion, due to the Glycerine

itself and this is of great value as in these cases there is always a metritis along with the displacement. The action of the Ichthyol is anodyne, antiseptic and resolvent. I am convinced that Ichthyol has a direct action in causing the absorption of old inflammatory products and this is borne out by its curative action in chronic skin diseases.

After removal of the tampon the patient is directed to douche herself with a weak solution of Condy's fluid. I always direct them to have the douche as hot as they can bear it, the external parts being smeared with Vaseline to prevent their being excoriated; this is repeated twice a day. The action of the hot douche is to cause an increased vascularity of the whole pelvic organs and so promote absorption, the Condy's fluid is added merely to make it slightly antiseptic.

In cases where Physiological rest was obtained recovery was much more rapid.

The purgatives I use may be termed by some, drastic; but I have found that in these cases mild measures are of no avail. In a number of these cases it is no unusual thing for the bowels to move only once a week, and in some of them even at longer intervals. I commence with Blue Pill, 5-10 grains of which are given at night, according to the requirements of the case. This is followed in the morning by a Drachm of Sodium Sulphate in a tumblerful of hot water. After this

treatment has gone on for a week, or a fortnight, according as the patient's bowels have become more active, or not, I stop the Blue Pill at night giving instead 15 m. of the Fluid Extract of Casc.Sagrad. with 5 m. of Liq.Strychninae thrice daily. The action of the Cascara is much enhanced by the Liq.Strychninae, indeed in cases where the Cascara seemed to have no action at all, the addition of the Strychnine brought about the desired result. Along with this, I continue the Sulphate of Sodium in the morning; the aim being to obtain at least one free evacuation of the bowels per day. This is absolutely necessary, for if the rectum is not absolutely empty, the mechanical part of the treatment cannot be carried out.

If the patients were anaemic, or run down, I gave a tonic, but in the vast majority of cases this was not required, as although the patients were pale or ashy in colour, this disappeared under the treatment described above, it being in fact, not Anaemia but Stercoraemia that was causing the cachectic appearance.

The Tympanites, of which a good number complained, disappeared when the bowels became regular, although in some, there was Gastric derangement as long as the Uterus was

displaced, it seemingly being dependent on the "Sympathy of the Organs."

As soon as the Uterus is replaced in its normal position; but not till then, I insert a pessary. It is a matter of importance that this should not be done too soon for a pessary inserted before the Uterus is free, and above the Sacral Promontory, not only does no good, but harm, by its injurious pressure on the displaced fundus. As regards the kind of pessary, I generally use a Hodge, which I mould to suit the individual case, the requisites being that the instrument should keep the uterus in good position, and cause no discomfort whatever to the patient. In some cases the ordinary "Ring" answers all the requirements. As regards the length of time to wear the pessary, I may say that it is kept in till the uterus shows no tendency to return to its vicious position. If we eliminate one case in which pregnancy occurred shortly after the insertion of the pessary, the shortest time that this result was obtained in was 9 months, and the longest 15, the average being 12.2 months, or a little over a year.

As regards the length of time that the above described treatment takes to allow of the insertion of a pessary,

it may be broadly stated to be from 2 to 4 months. Of the 17 annexed cases the displacement was reduced in 12 of them in that time viz:-

In 4 the displacement was reduced in 4 months.
In 3 Do. 3 months.
In 5 Do. 2 months.

Giving an average of 2.9 months. In connection with this it has to be remembered that the mechanical part of the treatment, was in some not carried out from the beginning as it could not be borne on account of the pain.

These cases we may put down as cured, as although some of them failed to report themselves regularly, and finally to have the pessary removed, yet we may assume that if their old symptoms had troubled them again they would have returned. In all probability they removed the pessary themselves.

Of the remaining five cases one (case XII.) became pregnant before the uterus had been free, and active treatment had therefore to be given up, with the result that the patient aborted, and not being properly attended, died. I had warned her of this possibility, and told her to go to the Maternity Hospital if pains came on; but she preferred to

call in a "handy woman" with the above result. Another (Case VIII.) gave up attending after 3 months during which time her symptoms had disappeared although the Uterus was not free. In Cases VII.X.and XVI., the adhesions were so dense that they could not be stretched, although in all, the symptoms were much relieved. In Cases VII.and X.,they returned again in 4 and 5 months, but disappeared on further treatment. In Case X. the whole pelvis was filled with old inflammatory exudation, so much so, that her medical attendant sent her up as suffering from a malignant growth of the pelvis.

As regards the disappearance of symptoms, it is remarkable how soon the patient begins to feel improvement from the treatment. This immediate result I believe to be almost entirely due to the action of the tampons and douching, plus the free action on the bowels. We know that displacement of the uterus alone won't cause symptoms; but that these are due to accompanying metritis, and endometritis, and to these the tamponade &c.are directed. The Glycerine causes a copious withdrawal of serum in the same way as a blister does, and to this we have added the resolvent action of the Ichthyol. I do not deny that these cases would be more quickly cured by a preliminary curettage but I do not consider it safe to carry

this out at an Out-patient Department for obvious reasons. As it is, the symptoms very soon disappear, in from a few weeks to a couple of months. Even in the cases where the displaced uterus could not be moved, there was marked improvement of the symptoms.

Of the 17 cases 12 or 70.6% were cured, in so much as the uterus was in normal position, either with or without a pessary, and all those who reported themselves a year after the insertion of the pessary were able to do without it, and their symptoms were gone. One patient (5·8%) died from an abortion, but this was not due to the failure of the treatment, as she had not been long under it when she became pregnant; another (5·8%) left off attending immediately after her symptoms had disappeared, and before the uterus was replaced. This leaves 3 cases or 17·6% of the whole number, in which the treatment employed was unable to replace the uterus, although it kept the symptoms in abeyance. Of these, two were admittedly very chronic cases, and one (Case X.) although she stated she had been ill for only 6 months, had very dense adhesions filling up the whole pelvis.

With regard to pregnancy, 4 of these patients, or over 23·5% became pregnant, although it must be added, that

two of them aborted at the third month, while the other two carried to the full time, and had living children. In one of the Cases (IV.) the chances are that she would have carried the full time had she not, of her own accord, removed the pessary, and so allowed the uterus to become again displaced.

In conclusion, I may remark, that I do not advance this method of treatment as a panacea for all cases of Fixed Retrodeviation of the Uterus. In some it is distinctly contra-indicated. In pregnancy it would be very risky, also if the Tubes contained pus, and I only employ it after I have absolutely made up my mind that there is no fluid in the Fallopian Tubes. It should never be attempted if there is any acute inflammation of the uterus, or its surroundings, nor if there is the slightest suspicion of Extrauterine gestation. In very fat women it would be very difficult of application, as owing to the thickness of the abdominal walls, we could not grasp the fundus after it had been raised above the Promontory of the Sacrum. But what I do claim is that it is a method of treatment suitable for an out-patient department, or for patients who prefer not to submit to operation, nay more, that the results obtained by it are better than those obtained by any other means except those claimed by Thuré

Brandt's Massage, the objections to which I stated above. Another point is, that in properly selected cases there is absolutely no risk to the patient, and in this way it is much superior to Schultze's method.

C A S E S:

CASE I:(Feb.5th.'95.) Mrs.P.aet 28. No children. Abortion at the 4th.month 7 mos.ago. Menstruation etc. regular till after the abortion, since then has been too copious, and every three weeks. Leucorrhoea moderate in amount. Great pain at periods. Pain in small of back since commencement of illness, increased by movement. Bowels costive. P.V.Uterus retroverted and fixed in Douglas's Pouch. Treatment usual. This continued till June when Uterus was replaced and ring inserted. The symptoms had disappeared by May but Uterus was still fixed in the Abnormal position. She wore the ring till January 1897, when it was taken out finally. In March 1897, she came to say that she had not menstruated since December 1896, and had been sick in the morning. P.V.Uterus showed signs of pregnancy. She was delivered of a living child in September 1897.

CASE II:(Feb.8th.'95.) Mrs.A.aet 28. Menstruation 14, married at 18; 4 children, twins 3 years ago. No abortions. At the birth of her twins she was very ill - 24 hours between the births - "shiverings" a few days after the births followed by "fever" and not out of bed for six weeks. Before this pregnancy

Menstruation was every four weeks since it has been every three, with clots and great pain. Leucorrhoea very slight. Pain across bottom of back. Bowels costive - once a week - frequent micturition. Dyspareunia.
P.V.Uterus is retroverted and fixed to the left side of Douglas's pouch. Treatment usual. Feb.15th. Noted to-day that Uterus is more moveable but still fixed. Symptoms much better. Apl.19th. To-day was able to replace Uterus and insert a Hodge. Seen again in May 1895 Uterus in good position and symptoms gone. Pessary washed and reinserted. Not seen her since, although told to return in two months.

CASE III:(Apl.21.'95.) Mrs.A.aet 25. Menstruation 15. Married 21, never pregnant. Menstruation regular till marriage, since then it has been profuse and painful - clots - and every three weeks. Shortly after marriage she had an illness, the symptoms of which were pain, Leucorrhoeal discharge and painful micturition. Since then she has never been quite well. At present she suffers from pain in back and left side increased by walking, Leucorrhoea moderate in amount and of a thick consistence and greenish in colour. Constipation.

P.V.Uterus is completely retroverted and fixed in Douglas's pouch. Treatment usual. May 21st. The symptoms have all gone but the uterus is still firmly fixed. July 5th. Able to reduce Uterus to-day and fit patient with a Hodge pessary. Saw her a month afterwards when she was still keeping well and uterus was in good position. She reported herself in October 1895, when she was still keeping well. Pessary was washed and reinserted. Uterus was in good position.

CASE IV: (May 14.'95.) Mrs.B. aet 26. Menstruation 16, one child 4 years ago. After this labour she was very ill "shiverings and fever" in bed for 3 weeks, and has "never been well since". Married 1 year ago, and symptoms have been increased since then. Menstruation regular - every 4 weeks - till pregnancy, since then every 2-3 weeks with clots and great pain. Dyspareunia. Leucorrhoea. Constipation.
P.V.Uterus retroverted and fixed in Douglas's Pouch. Right Ovary is also prolapsed and behind uterus. Treatment usual. June 11th. Much better as regards symptoms. P.V.as above. Augt. 13th. To-day Uterus was reduced, but Ovary was still in abnormal position, Hodge pessary inserted. Sept. Uterus still remains up; but Ovary is still to be felt high up

behind uterus. Symptoms gone. Dec.10th. Has not menstruated for two months, and is very sick in the morning. P.V.Uterus is soft and enlarged and is retroverted again (She had taken out pessary herself). An attempt was made to reduce it but without effect. She returned in March to tell me that she had had an abortion in January; but had made good recovery. P.V.,Ovary was still prolapsed but Uterus was in its normal position. As she suffered no inconvenience she declined further treatment.

CASE V: (July 9.'95.) Mrs.McN. aet 30. Menstruation 14, married 28. one abortion at 3rd.month two years ago, and has "never been well since". Menstruation regular till she became pregnant; every four weeks lasting 3 days. Since then it has been every three weeks, and lasts about a week with pain and clots. Leucorrhoea profuse. Pain in back and left side, bowels regular. P.V.Uterus retroverted, but not down into Douglas's Pouch and bound down to right side (Dextroverted) Treatment usual. Aug. 27. Symptoms practically gone, Menstruation normal a week ago, i.e., three days without

great pain or clots. Sep.10th. Pessary was introduced to-day Uterus much more moveable but not quite free. Aug.28th.'96. She has been coming back at intervals since last note to have pessary washed. She is now menstruating every 4 weeks and feels well. Pessary taken out and not reinserted. Last seen in December 1896, when she was still well.

CASE VI: (Oct.11th.'95) Mrs.G. aet 22. Menstruation 12. Married 19. One child two years ago, born with instruments. Had a "bad recovery" but no septic history can be made out. Nursed baby for a year, when menstruation began. It has been irregular, sometimes three weeks, sometimes a month and sometimes two months, and always accompanied by great pain and clots. Severe pain in back and left side. Dyspareunia. Constipation. P.V.Uterus is completely retroverted and fixed in Douglas's Pouch. Treatment usual. Decr.13th. Uterus replaced to-day and pessary inserted, symptoms all gone, except the Dyspareunia. June 1896, Patient has been reporting herself from time to time, and feels well. She has not menstruated since March, and Uterus shows signs of pregnacy. Pessary taken out. Delivered of a living

child in Decr. and has remained well since.

CASE VII: (Jan.7th.'96.) Mrs.McS.aet 24. Menstruation 14. Married 19 one abortion at 6th.month, four years ago. Menstruation regular and normal till abortion. Since then it has been very irregular 3 weeks, a month and 6 weeks. Dysmenorrhoea. No clots. Leucorrhoea thick and yellow. Pain in back and vagina "bearing down", constipation.

P.V.Uterus very firmly bound down in Douglas's Pouch, the broad Ligaments are felt to be infiltrated and very hard. Treatment usual. Febry.4th. The patient has been receiving treatment twice a week, but without much improvement. The physical signs are practically the same. Apl.14th. The symptoms are a little improved, but Uterus is still firmly fixed. Octr. 23rd. Except for "the bearing down" patient feels very well. Physical signs I.S.Q.Decr.4th. Patient feels well, but there is no change in the physical signs. Apl.2nd. 1897. Patient returned to-day with return of symptoms. Advised to House.

CASE VIII: (Jany.24th.'96.) Mrs.J. aet 33. Menstruation 13. Married 21. Two Children, youngest 10 years, both born natural. Appears to have a good recovery from both confinements. No abortions. Menstruation regular till 6 months ago, since then it has been irregular, sometimes 3 and sometimes 5 weeks. Copious. Dysmenorrhoea. Profuse Leucorrhoea for years with pain in back but not sufficient to make her lie up. For last six months the pain has been increased. Constipation.

P.V. Uterus retroverted and bound down in Douglas's Pouch. Both Broad Ligaments are much hardened. There is marked tenderness on examination. Treatment usual. Febry.14th. Leucorrhoea much less and pain not so severe. Physical signs I.S.Q. March. 24th. Says she feels quite well. Physical signs as above. Apl.17th. Still feels well. Uterus a little freer. Did not return.

CASE IX: (Jany.24.'96.) Mrs.I. aet 22. Menstruation 15. Married 19. 4 children, all born natural, youngest 5 years ago. After this labour she had a "weed", and was in bed for three weeks. Menstruation regular till after birth of last child, every four weeks. Since then has

been too frequent, about every three weeks. Menorrhagia and Dysmenorrhoea. Leucorrhoea profuse for a long time and is thick and white. Pain in right side and back for about the same duration as the Leucorrhoea. Constipation.

P.V.Uterus is firmly bound down to the right side and to the back. Very little tenderness on examination. Treatment usual. February 11th. Symptoms somewhat better, and Uterus a little freer. Apl.14th. Symptoms well. To-day was able to reduce Uterus and insert pessary. Uterus has still considerable tilt to the right side. May 1st. Pessary causing no discomfort, and patient feels well. May 14th.1897. Patient returned regularly to have pessary cleaned and Uterus remains in good position, although with a marked twist to the right. It was removed to-day and she was told to return in three months. Aug.20th. Patient presented herself to-day, remains well and Uterus is as above.

CASE X: (Aug.14th.'96.) Mrs.C.aet 57. Menstruation 14, married 17. Three living children, all born natural, youngest 30 years ago. Five abortions since then, last 26 years ago, widow for 15 years. Menopause at 40, and was well till six months ago, when she began to suffer from a thick cream coloured discharge, with painful micturition. She recovered from this in a few weeks, and has since suffered from pains in her sides and back. Doctor told her she had "Inflammation". She recovered from this acute pain in about 2 months, but the pain returned six weeks ago and the discharge which had never gone became more profuse. At present she suffers from pain in back and left side, which is much increased by movement. Marked constipation.

P.V. The whole pelvis is filled with a hard mass, which has the characteristic "Cement feel". The fundus of the uterus can be felt to be retroflexed and firmly fixed. Treatment usual. Aug.25th. Discharge much less, also pain. Physical signs I.S.Q. Oct.16th. Discharge stopped, pain gone, physical signs I.S.Q. Jany.22nd. 1897. Treatment has been kept up till now, during which time there has been no symptoms; but the physical

signs are unchanged. May 7th. Returned with slight return of pain and some discharge. These disappeared after 3 weeks treatment.

CASE XI:(Aug.14.'96.) Mrs.M. aet 30. Menstruation 13, married 24, an abortion shortly after marriage at the second month, and has "never been the same woman since". Menstruation regular till marriage; every four weeks. Since then it has been irregular, every three weeks, discharge scanty. Dysmenorrhoea. Leucorrhoea profuse. Pain in back and left side, which is always present but is much more severe at periods. Constipation. Tympanites. P.V.Uterus is retroflexed, and fixed in Douglas's Pouch, below fundus and to the right, the right Ovary is found prolapsed. Treatment usual. Sept. 8th. patient is much better, she menstruated last week, and there was great improvement as regards pain . Leucorrhoea much less. Uterus much freer as regards movement, but cannot yet be replaced. Oct.17th. Patient feels very well. Uterus replaced to-day, and pessary inserted, Ovary still prolapsed, but not tender. Last menstruation was "almost free from pain". Pain in the back gone, although she still has "a bearing down

sensation". Decr.4th. Patient has been very well since pessary was inserted. Menstruation has been regular and normal. Pain and Leucorrhoea gone. July 2nd.1897, patient has been coming every two months to have pessary washed. Uterus is freely moveable but right Ovary is still too easily palpable. Pessary taken out and patient told to report herself in 3 months. Oct.1st. Remains well and Uterus in good position.

CASE XII:(Aug.13th. '96.) Mrs.B.aet 24. Menstruation 16, married 23. Had an abortion at second month, 8 months ago. Menstruation normal and regular till then. Since then Menorrhagia. Leucorrhoea profuse. Pain in back and left side, and feeling of "bearing down". After the abortion the Doctor told her she had "Inflammation of the womb", and she was in bed three weeks. Constipation. P.V.Uterus is large retroverted and fixed. Utero-sacral Ligaments very hard and prominent. Broad Ligaments are soft, and Ovaries cannot be felt. Treatment usual. Oct. 23rd. Pain in back and side gone. Leucorrhoea much less though still present,Physical signs, I.S.Q. Nov.6th. A fortnight past her menstrual periods, and

sick in morning. Active treatment stopped in case of pregnancy. Jany. 15th. 1897. Suffers very much from sickness. Uterus a finger's breadth above pubes. P.V. Uterus is felt to be firmly bound down in Douglas's Pouch, and quite retort shaped. Febry. 2nd. Was told by a neighbour that Mrs.B.aborted 10 days ago and died yesterday. I had warned her that this might take place, and had told her to go at once to the Maternity Hospital. She had not done so; but called in a Midwife.

CASE XIII: (Aug.16th. '96.) Mrs.P.aet 29. Menstruation 17, married 25. One child three years ago, born natural. One abortion at third month before the birth of child. She states that she suffered from Gonorrhoea shortly after the birth of child. Menstruation was regular till then, since then it has been irregular, 5-7 weeks and very scanty. No Dysmenorrhoea. Profuse Leucorrhoea ever since her illness. Pain in right side for same period. Constipation.

P.V. Uterus is very much Dextroverted and Retroflexed. It is firmly fixed in this position. It is also enlarged. Treatment usual. Nov.27th. There has been steady improvement as regards pain and Leucorrhoea. Uterus is more

moveable, but cannot yet be reduced. Dec.18th. Pain and Leucorrhoea well. Menstruated last week, and the quantity was much increased. Uterus reduced, and fitted with Hodge pessary. Decr.25th. Pessary fits perfectly, and patient feels well. She is leaving Glasgow permanently next week.

CASE XIV: (Oct.13th.'96.) Mrs.R.aet 35. Menstruation 15, married 21. Three children last 6 years ago, all born natural. Two abortions since birth of last child. First at third month, and last 1½ years ago, at same period. Menstruated every three weeks since last abortion, before that every 4 weeks. Very scanty. No Dysmenorrhoea. Leucorrhoea profuse, thick and white since last abortion. Patient did not make a good recovery from last abortion, although she had no "shiverings". She suffers from pain in back and left side, which has gradually been getting worse, and from "bearing down". Bowels regular.

P.V. Uterus retroverted, and fixed in Douglas's Pouch. Tubes and Ovaries easily palpable, and feel thickened and hard, treatment usual. 5th. Febry.1897. Patient

has been coming regularly for treatment and all the symptoms except the feeling of "bearing down" has disappeared. To-day Uterus replaced, and patient fitted with a Hodge pessary. The Tubes and Ovaries are neither so easily palpable nor so hard as when first examined. Feb.12th. Patient returned to-day pessary fits well and Uterus in good position. May 14th. Patient returned to-day to have pessary washed. Her last two periods have been of the 4 week type, and more normal in quantity than before she underwent treatment. Decr.5th. 1897. Patient still keeps well, still wearing pessary. March 18th.1898. Patient has been coming regularly to have pessary washed. Uterus in good position, pessary taken out. March 25th. Patient reported herself to-day Uterus in good position.

CASE XV: (Oct.13th.'96.) Mrs.K.aet 42. Widow for 6 years. Menstruation 16, Married 20, five children, youngest 6 years ago, all born natural. One abortion after second child at second month. Menstruation irregular 2,4,7, weeks, has been so "for years", very profuse. Dysmenorrhoea. Leucorrhoea profuse, thick and cream coloured,

also "for years". Pain in right side in back and front, this has also been "for years", but has been much worse for the last month. Marked constipation, every 10 days or so.

P.V. Bowels are so loaded that examination cannot be made. Ordered purgatives. Oct.18th. Returned to-day for examination. Uterus is retroverted and to a slight extent dextroverted. Utero-sacral Ligaments are much hardened and thickened, marked tenderness on pressing on retroverted fundus. Treatment usual. Dec.12th. Much better, Leucorrhoea practically gone. Uterus more moveable but still unable to be reduced. Pain in right side much better. Retroverted fundus not now tender. Dec.19th. Leucorrhoea and pain gone. To-day I was able to reduce Uterus and fit patient with pessary. Febry.26th.1897. Feels well, pessary causing no discomfort. P.V.Uterus in good position. Apl.9th. Came up to-day to have pessary washed. Uterus in good position, patient feels quite well. Have not seen her since.

CASE XVI:(Jany.15th.'97). Mrs.S.aet 48. widow for five years. Menstruation 12, married 22. Five children, last 12 years ago, first with instruments, the others natural. Three abortions, two at 4th. month, and one at 11th.week. The abortions were all before she had a living baby. She has been ill for many years; but worse since her husband's death, as she has to go out to work. Menopause two years ago. Leucorrhoea for a long time. Great pain in back shooting up to shoulders, also pain in left side. These pains have been present for many years; but have become worse during the last four months. Constipation.

P.V. Uterus is very firmly fixed in Douglas Pouch, and cannot be moved in the slightest by very firm pressure. Ovaries and Tubes cannot be felt. Treatment usual. March 26th. Patient has been coming regularly. The pain continues severe, although the Leucorrhoea is decidedly less. Apl.30th. Pain in back and Leucorrhoea much better, no difference in the Physical signs. June 4th. Pain and Leucorrhoea gone, and she feels much better than she has done for years. The Uterus is so firmly fixed that it cannot be moved. Oct.22nd. Patient

has been coming regularly, and has remained free from symptoms, but the fixed retroversion remains. Told to return if she felt pain or Leucorrhoea again.

CASE XVII: (Jany.22nd.'97). Mrs.McC. aet 29. Menstruation 14, married 17. One abortion at 3rd. month 8 years ago. She was very ill after this, and has "never been the same since". Menstruation regular, but very severe Dysmenorrhoea and the quantity is profuse and clotted. Leucorrhoea profuse, thick, and cream coloured. Pain in left side and back and "bearing down". These symptoms have been more or less present since abortion; but have become very much worse of late. Marked constipation. P.V. Uterus is retroverted, and fixed in Douglas's pouch. There is considerable tenderness of the retroverted fundus. Ovaries and Tubes can be felt to be thickened and hardened. Treatment usual. March 19th. Menstruated last week. Pain not nearly so bad and quantity less. Leucorrhoea very much less. Uterus much freer, but still bound down. May 7th. Leucorrhoea and pain gone. To-day I was able to reduce the Uterus, and fit patient with a pessary. May 14th. Pessary fitted well and uterus in good

position. Patient menstruated last week, and it was the most normal period she has had, both as regards pain and quantity since her illness began. Nov.5th. Patient feels well, still wearing pessary. Uterus in good position.