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THE PRESENT POSITION OF THE PESSARY IN GYNECOLOGICAL PRACTICE

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THE examination of the Transactions of this Society, published during the last thirty years, reveals the fact that the question of the employment of pessaries engaged the attention of the Fellows on exactly ten occasions[1] during that period of time. Seven of these ten occasions were prior to the year 1880, and only one was in the last decade. On only one of these occasions was the communication to the Society of the nature of a paper; in all the other instances it consisted in the exhibition either of a newly invented pessary or of an old support which had been worn in the vagina for a long term of years (five in one instance, sixteen in another). The precise amount of space in the Transactions occupied by the record of these ten communications was six and a half pages. Six and a half out of a total of five thousand four hundred and sixty-three pages does not appear to be an excessive amount of space to have set apart for the consideration of pessaries during thirty years. Further, the employment of vaginal supports is a matter which has scarcely at all come before the Society even in connection with other subjects of discussion. Some of the Fellows, and notably Simpson, have incidentally adverted to their use, while one Fellow has strongly anim-

[1] *Trans. Edin. Obstet. Soc.*, vol. i. p. 42; ii. p. 47, 217, 360; iii. p. 288; v. (2) p. 144; v. (3) p. 140; x. p. 163; xii. p. 128; and xviii. p. 68.

adverted on their employment (I mean Berry Hart,[1] in his admirably suggestive paper on a "pathological classification of the diseases of women"); and Croom[2] has emphasised the dangers of intra-uterine stems in his "criticism of some of the lesser gynecological manipulations." These, however, have been passing references to pessaries, and I think I am right in stating that the question of their employment under the greatly altered conditions of modern gynecological practice has not been brought fully and formally before the Society.

It may be concluded from the paucity of references to pessaries in the Transactions of our Society that this means of gynecological treatment is so extensively employed and has its indications so exactly established as to give rise to no questions calling for discussion. It may also, and with the same degree of probability, be regarded as proving that the use of pessaries by the Fellows of the Society has been almost, if not quite abandoned, and that consequently nothing more remains to be said about it. A little thought, however, will be sufficient to show that it is still more probable that neither of these conclusions is warranted by the facts which are available for examination.

If an excursion be made into the territories of professional opinion and practice lying outside the necessarily limited area of the discussions which have taken place in this Society, it will, I think, at once become apparent that the use of the pessary is very far from being one of these matters about which it can be affirmed that the last word has been said. It will, indeed, be found that gynecological opinion concerning this question is best described as in a state of flux.

I have endeavoured to form an estimate of the present position of the pessary in gynecological practice by an inquiry into the evidence bearing on the subject found in current medical literature (in text-books and journals) and in the experience of instrument-makers supplying the profession, and so able to gauge the trend of professional opinion on this subject. I have also incorporated, what is of much less importance, my own method of procedure in dealing with the gynecological cases which are generally regarded as requiring treatment by pessaries.

[1] *Trans. Edin. Obstet. Soc.*, vol. xix. p. 82, 1894.
[2] *Ibid.*, vol. xvi. p. 25. 1891.

Before proceeding to extract from medical literature information on the status of the pessary in present-day practice, I may briefly refer to the evidence obtained from surgical instrument-makers on the demand for the various forms of uterine support now observed by them. I put to them certain questions, and I obtained the following answers :—

(1) During the last twenty years there has been a steady increase in the number of pessaries sold to the medical profession.

(2) Along with this increase in the total number sold there has been a steady decrease in the number of varieties asked for, so that at the present time the ring and the Hodge, in some form or other, and occasionally the vaginal stem with an abdominal belt, constitute practically the only ones in common use.

(3) Medical men show a marked tendency, after trying various forms of the Hodge, to return to the Albert Smith modification in vulcanite, and after testing rings of different kinds, to revert to the use of the simple india-rubber instrument containing a watch spring.

(4) More marked than the increase in the use of pessaries has been the growth in the demand for uterine curettes, and more especially for that variety commonly called Martin's. The increased sale of curettes, especially during the last six years, has been, so I am told, phenomenal ; and along with it there has been a very striking decrease in the popularity of caustic-carriers and instruments of that type.

(5) Intra-uterine stems are hardly ever asked for.

Such were the answers given me by the Edinburgh instrument-makers, and the inspection of the catalogues of makers elsewhere on the whole supports the notion that there has been a general increase in the use of pessaries by the profession and a decrease in the varieties so used. No doubt local influences have been at work in determining to some extent what shall be the favourite form of support in different places.

It is now necessary to inquire whether medical and more especially gynecological literature contain such references to pessaries and their use as will enable us to state that in this matter specialists and the general practitioner are at one in their opinion and practice. In order to arrive at some conclusion on this matter, I have taken twenty well-known text-books on Gynecology, all published within the last ten years, and

have analysed and epitomised the views on the employment of pessaries therein contained. The text-books selected were (in alphabetical order) those of Baldy, Balls-Headley, Bushong, Dührssen, Garrigues, Harrison (in Mann's System of Gynecology), Hart and Barbour, Herman, Küstner (in Veit's Handbuch der Gynäkologie), Labadie-Lagrave and Legueu, Lawson Tait, Lewers, Macnaughton-Jones, Mundé (in Keating and Coe's Clinical Gynæcology), Phillips, Pozzi, Simpson (in Playfair's System of Gynæcology), Skene, Webster, and Winckel. As far as possible I took the latest edition of each of these works. In some instances I found it a little difficult to form an opinion as to the author's own views on pessaries on account of the impartial way in which the subject was discussed; but generally there was sufficient evidence to indicate whether the writer was an ardent supporter of the mechanical treatment of displacements or not.

With regard to the primary question of the attitude of these authors to the use of pessaries in general, the result of the inquiry was as follows:—Eight were strongly in favour of this method of treating uterine displacements, five were strongly against it, and seven were critical and even sceptical without actually going so far as to condemn the method and banish the instruments. It is, however, necessary for me to qualify this statement to a certain extent. The most pronounced advocates of the pessary do not deny that it has inconveniences, that it requires to be used with care and intelligence, that it seldom really cures, and that it occasionally must give way to operative procedures. On the other hand, those that are most strongly opposed to its employment admit that there is a small residuum of cases in which the pessary either may or must be used. Further, the critical writers are not equally critical about all forms of pessary, and many of them freely concede that treatment by pessaries is fully justified in certain kinds of displacement although not in all. With this qualification I repeat that eight gynecological authors (Herman, Küstner, Lewers, Macnaughton-Jones, Mundé, Phillips, Simpson, and Winckel) were in favour of treatment by pessaries; five (Baldy, Balls-Headley, Bushong, Lawson Tait, and Pozzi) were much opposed to it; and seven (Dührssen, Garrigues, Harrison, Hart and Barbour, Labadie-Lagrave, Skene, and Webster) held views which are best described as intermediate.

It may be well if I first set forth the chief objections that have been raised against the use of pessaries in general without in the meantime specifying any special kind of cases.

General Objections.

1. *Inconvenience.*—It has often been stated, and of course with perfect truth, that the wearing of a pessary is an inconvenience, amounting in some persons to unpleasantness. It necessitates periodic visits to the medical adviser, and leads to an unhealthy feeling of dependence upon him; it entails frequent if not daily vaginal douching; it may set up or aggravate a malodorous discharge; and it may (if certain kinds be used) interfere with marital relations. Balls-Headley, it may be remarked in passing, magnifies the last-named inconvenience into a danger to morals, for he says that the pessary thus "strikes at the root of the institution of marriage, and especially of monogamy."

2. *Inefficiency.*—Some gynecologists have been so firmly convinced of the inefficiency of even properly adjusted, well-fitting and carefully used pessaries, as to doubt whether they ever are the cause of relief from symptoms; most have no doubt at all that they never really cure, in the sense of complete restoration of the normal position of parts. "I hate pessaries, and I never use them if I can help it," are the words of Lawson Tait; and in another place in his book he says that he has "many times wished that pessaries had never been invented." At the same time he admits that there are cases in which he is compelled to employ them, and he then uses either Fowler's cup pessary, or the "wedge" devised by himself. Even strong supporters of the use of pessaries generally admit that they very rarely cure, and are really temporary or half measures; and more need not be said regarding this aspect of the objection of inefficiency. But some go the length of asserting that they have not even the power of truly relieving symptoms. They aver that the evidence of patients who say their symptoms are removed is apt to be misleading; the support may be actually doing harm by still further damaging the natural supports of the uterus. The Zwanck pessary may be efficient in the sense of keeping up a prolapsed uterus for a time, but its efficiency is in the long run dearly bought. The

displacement is treated but the cause is not removed, it is indeed aggravated.

3. *Injuriousness.*—It has been further alleged that pessaries are not only ineffective, but also injurious and even dangerous. Some gynecologists have stated this objection moderately, and have made exceptions as to certain kinds of pessaries used in certain cases and in certain kinds of ways: the intra-uterine stem, the Zwanck, and the large ball pessary have come in for special condemnation, while the ring and the Albert-Smith carefully used and in suitable cases have generally been acquitted. Other writers, again, have regarded as dangerous all pessaries, even the indifferent ones; and among the evil results attributed to their use have enumerated pruritus, vaginitis, ulceration, fistulus formations, the prevention of union of a torn cervix, subinvolution, cancer, and septic inflammation of the uterus and tubes.

Such are the leading objections that have been urged against the employment of pessaries in general, and I may perhaps best sum up this side of the matter by again quoting from Balls-Headley, who confesses that he is an "apostate from complete faith in pessaries" after having been an intense believer. He asks what conditions then may be said to be left in which pessaries may be used, and he answers: a "few cases of parous normal os with retroflexion, or prolapse from subinvolution of the endometrium and broad ligaments, and moderately lacerated perineum in women who refused or were unable to have the proper treatment for subinvolution or repair of the supports adopted, and whom it may injure, never cures, but occasionally relieves." "With advancing knowledge, pessaries, like bleeding, will cease to be."

General Advantages.

1. *Convenience.*—All the strong supporters of treatment by pessaries emphasise their convenience. An occasional visit to a gynecologist, occupying probably only a few minutes, frequent vaginal douching, which possibly would be required anyhow, a transitory feeling of uneasiness in the pelvis when the pessary does not exactly fit or has been worn rather too long, cannot surely be regarded as sufficient reasons for advising a patient to face the ordeal of a plastic operation with all its incon-

venience, its expense, and its enforced confinement to bed for a longer or shorter time. As Mundé puts it, "Not every patient who has a displacement of the uterus wishes to be operated upon for its permanent cure." Further, there are the cases in which it is impossible for the patient, either on account of her advanced age or her occupation, to have any operation at all; in such instances the pessary becomes a great convenience.

2. *Efficiency.*—The opinion of all who make much use of pessaries in their gynecological practice is that they are undoubtedly effective in relieving symptoms. Some go further and state that they in many cases produce a permanent cure in a longer or shorter time. Mundé, speaking of recent displacements, affirms that in about twelve cases in a thousand the pessary may in a year or two be no longer needed. He says further: "No tampons, no astringents, no massage, no electricity, no posture, no baths, no vaginal douches, will, in my experience, take the place of a properly fitted vaginal pessary." Herman, writing on prolapse, says that "If a vaginal pessary is retained and keeps up the uterus, relief is almost complete and greater than can be obtained in any other way"; and in referring to chronic retroflexion, he believes that only about one case in fifty calls for any other methods of treatment than that by pessaries. Lewers goes further than most of the advocates of the preferential treatment of displacements by pessaries, for he affirms in relation to prolapse that "no plastic operation will cure cases of procidentia; no matter how complete the success of the operation may appear at the time, unless the patient wears a pessary, the displacement will most probably return as badly as ever. If, however, she wears a ring, a permanent condition of comfort is obtained." Macnaughton-Jones has no doubt as to the efficiency of the well adjusted pessary, for he asserts that "in all forms of displacement where its employment is clearly indicated, it generally gives material relief." The advocates of pessaries may differ in their views as to the manner in which these instruments relieve symptoms, but that they do relieve symptoms all are agreed. That they are effective means of treating displacements is, therefore, urged as their great advantage.

3. *Safety.*—Most gynecologists freely admit that the ordinary vaginal pessaries used with ordinary care are perfectly

safe; but those who strongly advocate their use claim that even intra-uterine stems and instruments of the Zwanck type are quite innocuous. The bad results that are occasionally reported are ascribed by these pessary-partisans to want of care in adapting the pessary to the person, and to absence of precautions on the part of the patient wearing it. Several writers state that pessaries of the nature of the Zwanck must be taken out every night by the woman herself and replaced in the morning, and they do not apparently fear that she may be unable or unwilling to do so, nor do they dread any evil results from her want of knowledge of the anatomy of the parts. All these authors emphasise the safety of the pessary as contrasted with the danger of other, and especially of surgical, methods of treating displacements; and to them the remark made by Lawson Tait that he is certain that removal of the ovaries is "a far safer proceeding than the employment of intra-uterine stems, and has the merit of being effectual" must appear extraordinary indeed.

I have thus placed in order, the one over against the other, the statements of the strong advocates of pessaries and those of the strong opponents to their use. It is now necessary to take some notice of the gynecologists who give a critical approval to the employment of certain kinds of pessaries in certain kinds of displacements and under certain circumstances. This can best be done by considering the various displacements.

Pessaries in Prolapsus Uteri.

1. *Incomplete Prolapse.*—In cases of incomplete prolapse, where the perineum can still be depended upon to make retention of the pessary possible, many gynecologists recommend the india-rubber ring or Hodge-Smith, with or without transverse bars (according as there is or is not some degree of cystocele). It is claimed for this method of treatment that it relieves symptoms, that it keeps the replaced uterus in its place, and that it so gives time for the normal uterine supports to regain their tone. It is further thought that should a pregnancy occur, or the climacteric be near at hand, this benefit may become permanent, and a real cure be effected. Most authors, however, are of opinion that the treatment by pessaries

is in these cases only palliative, and the relief temporary. The alternative kinds of treatment in incomplete prolapse, with a certain degree of perineal efficiency, may be stated to be (1) the purely palliative plugging of the vaginal vault with glycerine or ichthyol tampons, with or without rest and douching; (2) uterine curettage to diminish the uterine subinvolution and restore tone; (3) anterior colporrhaphy, especially when there is marked cystocele; (4) perineorrhaphy even when the perineum is not markedly defective; (5) ventro-fixation of the uterus (not often); and (6) Alexander's operation (not often).

(2) *Complete Prolapse.*—In cases of complete prolapse, where the perineum has almost or entirely lost its power of retaining a pessary in the vagina, the only form of support which is possible is the stem, with an abdominal belt and outside straps and perineal pad. The Zwanck and all instruments with hinges and screws are now generally regarded as both unsatisfactory and dangerous. Even with such stems and belts as in Cutter's pessary the relief afforded is only precarious, and often quite illusory (Pozzi). The only cases in which most gynecologists would countenance the wearing of such supports are in old women who either refuse or are too weak to be subjected to operative procedures, or in younger women who absolutely decline to be relieved in any other way. The most hopeful view that one can take of treatment by pessaries in these cases is that by their means a complete prolapse is turned into an incomplete one, and that in time it may be possible to replace the stem and outside straps by a single vaginal pessary (A. J. C. Skene). It is well to bear in mind that it is quite necessary before inserting a Cutter's stem to cure ulcerations and erosions on the cervix. It is questionable whether in all these cases equally satisfactory (or rather equally unsatisfactory) results might not be obtained by means of plugging the vagina tightly with marine lint, and renewing the packing every third or fourth day. The alternative procedures to pessaries in the treatment of complete prolapse are (1) perineorrhaphy; (2) colporrhaphy, anterior or posterior, or both, with or without perineorrhaphy; (3) ventrofixation of the uterus; (4) Alexander's operation; and (5) vaginal hysterectomy.

The rules which I have laid down for myself, and which

I always attempt to carry out in cases of prolapse, are as follows:

In incomplete prolapse I endeavour first to exclude the physiological prolapse of an early pregnancy, and second, I try to assure myself that the symptoms from which the patient suffers are due to the displacement itself, and not to concomitant conditions. As a general rule, no pessary is referred to or used on the first occasion of seeing the patient, but a simple tampon of cotton wool is introduced into the vaginal vault. At the second visit I am usually better able to determine to what extent symptoms are due to the prolapse, for in the interval the patient has been regulating the bowels. Not infrequently no further treatment than the care of the bowels associated with the occasional introduction of a glycerine tampon and vaginal douching suffices to remove symptoms, and the patient is possibly saved from a long course of pessary-wearing. In other cases symptoms persist, and I then in accordance with the condition of the perineum and uterus suggest either perineorrhaphy or curettage, the former when the cause of the prolapse seems chiefly to be due to weakening of the pelvic floor, the latter when it seems to be increase in the weight of the uterus. Sometimes both these operations may appear to be needed, then both are suggested. If, however, the patient do not wish to undergo an operation, I conceive it to be my duty to state what amount of relief she may expect to receive from wearing a properly fitted pessary, what inconveniences its wearing will entail, and what amount of medical supervision it will require. These matters having been explained, I then endeavour to adjust a pessary, generally a ring, to the vagina, often trying several before finding one which keeps up the uterus, gives no pain, and is retained. I instruct the patient to return if pain or vaginal discharge supervene, and at anyrate to come back in a week for examination, to use the douche twice in the week, and to avoid great exertion. If all goes well the patient will only require to return once in six weeks or two months, after the proper size of pessary has been arrived at, to have the support taken out, washed, and reinserted. I have under my care now a lady who, when I first saw her, was almost incapacitated from active life by a condition of moderate prolapse, with considerable enlargement of the cervix. Operative measures were

proposed, but absolutely refused. A simple ring was then fitted to the vagina. The patient comes to me four times a year to have the support seen to, and, to use her own words, is in the intervals quite unconscious that she is wearing any support for the womb at all. She leads a very active life, suffers from no vaginal discharge at all, and has no pain. At the end of four months the pessary is not offensive. In another very similar case the pessary requires to be changed every month, and even then is distinctly offensive. I can find no satisfactory explanation for this difference, which I have noticed in other instances.

I think, therefore, that in cases of incomplete prolapse it is right to suggest radical means of treatment first, but if these are objected to, I do not think that I am justified in withholding the treatment by pessaries after I have explained that their action is palliative. On the other hand, in cases of complete prolapse I recommend operative treatment, and even when patients object to it I still do not advise pessaries. I leave it to the patients to introduce the question of treatment by pessaries, and when they do I do my best to persuade them against it. It is with the greatest reluctance that I allow myself to be persuaded into treating any one save an old and feeble patient with such contrivances as vaginal stems with outside straps. These are necessary evils, perhaps, but I wish to be very sure that they are necessary.

Pessaries in Antrorsions.

1. *Anteversion.*—Most authors are now agreed that to try to treat anteversion of the uterus by pessaries is to use means which are inadequate to remedy a condition which is not itself productive of trouble. If, however, an enlarged, chronically inflamed uterus is more or less fixed in an anteverted position, then symptoms arise which are due immediately to the metritis. Consequently most gynecologists treat the metritis and the metritis only, and in doing so do not invoke the help of pessaries; but some think that the insertion of an indifferent pessary, such as the ring, is of value in hastening the cure by raising the uterus. Labadie-Lagrave, for instance, treats first the metritis, and when various means fail, endeavours to replace the uterus either by a hypogastric belt or by a ring pessary;

with regard to such instruments as Graily Hewitt's cradle, he says: "Mais beaucoup de malades ne peuvent les supporter, et souffrent davantage lorsqu'ils sont en place!"

2. *Anteflexion.*—That sharp anteflexion of the uterus and certain well known symptoms, such as dysmenorrhoea, sterility, and bladder irritability, commonly coexist must be admitted by all; but there is a vast difference of opinion among gynecologists as to the part played in the production of these symptoms by the displacement. Some doubt whether the anteflexion itself causes any symptoms, and are in consequence opposed to the use of pessaries. Others see in the displacement the immediate source of all the trouble, and are only in doubt as to the particular kind of pessary to be employed. I think most authorities are now agreed that a congenitally fixed and flexed uterus is not amenable to treatment by pessaries. Another point about which there seems to be general agreement is that no vaginal pessary will straighten an anteflexed uterus even when the uterus is fairly movable. The question in anteflexion and its treatment by pessaries has therefore narrowed itself down to the justifiability of employing intra-uterine stem pessaries. Even strong advocates of treatment by mechanical supports are in doubt whether the risks attendant upon wearing intra-uterine stems do not more than counterbalance any good effects which may arise therefrom. The dangers and risks incident to the wearing of stem pessaries are well set forth by Skene, a gynecologist who is by no means opposed to the use of pessaries in general; the chief are sepsis, inflammation and the perforation of the uterus. Various devices have been adopted to render intra-uterine stems innocuous, and while it cannot be said that anyone has succeeded, it may be admitted that the entirely intra-uterine (*i.e.* without a vaginal portion) pessary recently brought forward by Lefour comes nearest to the standard. It has been not infrequently claimed by the advocates of intra-uterine stems that menstruation, scanty and accompanied by great pain before the introduction of the stem, becomes profuse and painless after it has been placed in the uterus; but opponents of the stem point out that the pessary in such cases, instead of draining away discharge, has really produced the discharge by setting up suppuration, and has led to lesions that take months to heal (Baldy). Indeed, there seems to be a very widespread feeling that intra-uterine

stems are too dangerous for ordinary use. Lawson Tait, in his remarks on displacements to the front, says, "the only local treatment that will be of the slightest use is the galvanic stem, and that is far too risky!" Winckel is an exception, for he "remains an advocate of intra-uterine elevators, although employing them less frequently than formerly"; he uses them in anteflexions after the inflammatory symptoms have disappeared.

What then, it may be asked, are the alternative methods of treating the symptoms associated with antrorsion of the uterus? In many cases it is the metritis that causes the symptoms, and in these the treatment is that of metritis—douching, ichthyol, plugging, curettage, cauterisation. In others it would seem to be the coexisting undeveloped state of the uterus and especially of the cervix which is at the root of the trouble; then the occasional passing of the uterine sound, cervical dilatation, division of the cervix, and electricity (*e.g.* negative pole internal, five minutes of a current of from 50 to 80 m.a. twice a week for a month or six weeks, Milne Murray), and in very grave cases removal of the ovaries.

In my own practice I have used pessaries scarcely at all in antrorsions of the uterus. I look upon the normal position of the uterus as one of *mobile* anteversion with a small degree of anteflexion, but I place more emphasis upon the condition of mobility than upon that of direction. Consequently, so long as there is uterine mobility I do not think of treatment by pessaries save only when I find an enlarged and subinvoluted organ lying anteriorly, and at a slightly lower level than usual when the insertion of an indifferent pessary, such as the ring, may occasionally give temporary relief from symptoms. When, on the other hand, there is not uterine mobility, pessaries are in my opinion, neither safe nor effective. In these cases recourse has to be had to measures having as their object the relaxation of adhesions: the minor gynecological methods such as ichthyol tampons and the douch I by no means despise, curettage I sometimes use but with great caution, and with the growing conviction that in this operation under these circumstances it is probably the dilatation rather than the scraping that does good. Electricity I have not yet had occasion to employ, but I intend to use it in obstinate cases. Finally there is, I believe, a large number of instances in which the symptoms are really due to rheumatism affecting the uterine muscle, and then I find the

employment of anti-rheumatic remedies internally with the abandonment of local treatment in the pelvis will often give great relief to the patient.

Pessaries in Retrorsions.

While pessaries are coming to be looked upon as unnecessary and ineffective in antrorsions, and as temporary and palliative props in prolapsus it is evident that the mind of the profession is far from made up on the question of their use in retrorsions of the uterus. That this is so is fully borne out by the perusal of gynecological text-books and current medical literature. Writing on retroversions, Skene sums up thus:— "At the present day, I presume, that if the harm done should be placed opposite the good accomplished by all the pessaries in use, the results would be about equally balanced. It follows then that as matters stand at this moment it is a question whether the human race would be better or worse if all the pessaries were put out of existence. The all important fact remains, however, that pessaries are of great value and capable of giving relief to those who suffer from some of the forms of uterine displacement, if properly used." Another circumstance, almost as significant in its way as this quotation from Skene, is the fact that several writers on gynecology have found it necessary to consider the question of pessaries in retrorsions under a number of headings. Thus, J. C. Webster divides cases of retroversion into seven classes and gives special direction for the management of each. It will be of service in demonstrating the difficulties met with if I give a synopsis of Webster's mode of grouping retroversions (and the same applies to retroflexions) in reference to their treatment by pessaries.

1. In retroversion with a uterus fixed by peritonitic adhesions no pessary is to be used.
2. In retroversion with a freely movable uterus, not enlarged, and with no pelvic trouble there is no necessity for reposition and the pessary, but if there is bronchitis or the lifting of weights, then it is well to keep the uterus anteverted by a pessary.
3. In retroversion of a freely movable puerperal uterus with no pelvic trouble there is no need for a pessary,

but if there are to be strains and lifting weights, then use a Hodge or Smith pessary.

4. In retroversion of the pregnant uterus use a Hodge or Smith up till the fourth month.
5. In retroversion with a movable uterus, with pelvic symptoms, but with neither ovary in the pouch of Douglas, use the Hodge or Smith.
6. In retroversion of a movable uterus with pelvic symptoms, and with one or both ovaries in the pouch of Douglas, use no pessary till the ovarian inflammation has been diminished by douching and plugging, then use first the ring, and afterwards the soft Hodge or Smith or Thomas.
7. In retroversion of a movable uterus with pelvic symptoms and old posterior perimetritis or cellulitis, follow much the same lines as those in the preceding rule.

Dr Webster gives, I think, a very fair statement of the views on the use of pessaries in retrorsions which are held by those who are neither strong advocates nor strong opponents of pessaries in general, but are more or less critical regarding them. The question of the treatment of retrorsions by pessaries is the watershed dividing the two currents of opinion on the subject of the employment of pessaries in general.

This communication has already grown too long to warrant me in giving the various arguments pro and con the use of pessaries in backward uterine displacements, but it may be helpful if I pick out one or two leading points of interest. It seems, for instance, that most authorities are now agreed that it is necessary to replace the uterus before inserting a pessary. Herman is peculiar in thinking that the simple introduction of the Hodge will antevert a retroverted uterus; he admits that it will not effect this with a retroflexed organ, and establishes a distinction between retroversion and retroflexion founded not on symptomatology but on treatment in consequence of this difference in behaviour with the pessary. It seems also to be pretty generally accepted that in many instances the correction of a posterior deviation of the uterus by a pessary is followed by an amelioration or a total disappearance of the symptoms; but all are not agreed as to the manner in which this result is brought about, some ascribing it to the replacement of the uterus itself, and others to the

relief of the concomitant morbid changes in the pelvis thus rendered possible. There is also general agreement that in retrorsions, pessaries scarcely ever effect a permanent cure; that is to say the giving up of the wearing of the instrument generally results in the return of the symptoms. There is an evident and growing tendency to treat first the so-called complications before resorting to the use of pessaries; and hence it has come that uterine fixation, uterine tenderness, ovarian prolapse and tenderness, and pelvic peritonitis and cellulitis have all been recognised as contra-indications to the immediate employment of pessaries. An increase in this tendency will inevitably result in a great diminution in the number of cases treated by supports, for the curing of the complications will often make any further treatment by pessaries or otherwise unnecessary.

The alternative methods of treating the symptoms associated with retrorsions are vaginal tamponing, uterine curettage with or without intra-uterine cauterisation and vaporisation, pelvic massage, cervical amputation, vaginal fixation of the uterus, ventro-fixation, and the Alexander-Adams operation. Looking back over my personal experience in the treatment of the symptoms closely associated with retrorsions of the uterus, I am struck by the difficulty I have had in deciding upon the means to be adopted in individual cases. Under certain circumstances the line of procedure has been clear enough; thus in all the cases of retroversion of the gravid uterus that I have met with, I have obtained perfectly satisfactory results from replacing the uterus and inserting a Smith pessary, which the patient wore till about the fifth month of her pregnancy; while in all the instances of retrorsion of the uterus in the unmarried that I have seen I have not used pessaries, and have nevertheless been able to relieve the symptoms in most. But outside these two groups of cases I confess I have often had much thought as to the right line of treatment to be followed. For instance, I have under my care now a patient with a movable, slightly enlarged uterus, retroverted and slightly retroflexed; more than four years ago I inserted an Albert Smith pessary, with the result that the symptoms, which had been so marked as to prevent the patient doing her ordinary house work, completely disappeared; from time to time I have intermitted the use of the support with the consequence that the symptoms returned; about two years ago pregnancy occurred and ended

normally, but the pessary had to be resumed again after the puerperium. This patient refuses to consider operative means, urging that as long as she wears the instrument she feels quite well and has a normal menstrual flow. The patient's symptoms are entirely relieved, but can it be said that she is cured? In contrast with this case let me cite another; it is one of chronic endometritis in a retroverted uterus with symptoms, especially at the menstrual times, incapacitating the woman from the ordinary duties of life. I explained to her the probable advantages of immediate operative measures over the prolonged treatment by pessaries, and got her free permission to curette the uterus; this was accordingly done, the state of the mucous membrane apparently justifying the means employed and encouraging the hope of a permanent cure. No such good result, however, has followed, and I have been compelled to have recourse to the despised pessary which is now affording the patient the desired freedom from symptoms at any rate.

In the main, I find myself being guided in the treatment of retrorsions by the same considerations as J. C. Webster has set forth and to which I have already alluded; the occupation of the patient, the condition of fixity or mobility of the displaced organ, the presence or absence of pelvic symptoms, and the presence or absence of such complications or concomitants as ovarian prolapse or pelvic peritonitis all help us to determine whether the pessary is to be the means of treatment chosen or not.

There is one point to which it is necessary for me specially to refer in conclusion. It is that there is the greatest need for a fuller consideration of the selection of the pessary to be used in the individual case than is usually given. In the treatment of retrorsions this is peculiarly needful, for the pessaries used in such cases ought to be as nearly as possible moulds of the vaginal canal; in size, in shape, and in curvature, they should correspond to the size, shape, and curvature of the vagina. It may be that the support will require to be changed several times before a satisfactory result is obtained.

I have not touched upon pathological or congenital retroflexions, but I may say that I regard them as governed by the same laws as the pathological anteflexions.

It must be regarded as borne out by all the evidence that has been brought together that, taking a wide view of the place

of pessaries in modern gynecology, we must look upon them as still having a sphere of usefulness within which their value certainly as palliatives and possibly also as curative means must be conceded. It has been said by Mundé that "a pessary" (he is writing specially of retrorsions) "is a necessary evil"; but I venture the assertion that pessaries are necessary, and not necessarily evil.

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