PESSARY THERAPY

Pessaries are employed for the purpose of maintaining a retrodisplaced or prolapsed uterus in place and to support a cystocele. In the case of a prolapse of the uterus or a cystocele a pessary is only of value as a palliative measure where operative relief is refused or is undesirable on account of the age or condition of the patient. In a certain proportion of retrodisplacements, however, a properly fitted pessary will in time produce a cure, the most favorable cases being those in which the displacement is only of short duration as, for example, after confinement. The only cases of displacement in which pessary therapy is suitable are those where the pelvic floor has sufficient tonicity to give support to the pessary and where the displacement is not complicated by pelvic lesions. Their use is contraindicated in the presence of considerable enlargement or a prolapse of the ovary, hydrosalpinx, pyosalpinx, or new growths, and where the uterus is bound down by adhesions. Some cases of adhesions, however, under appropriate treatment by medicated tampons, hot douching, etc., may be so stretched or even be made to disappear that later a pessary may be satisfactorily employed.

Pessaries are not designed as a means of replacing a uterus, but simply to hold the organ suspended in proper position after it has been replaced. This it does by distending the vaginal walls, and not through any force exerted by the instrument upon the uterus itself. Every pessary should be fitted to the individual case, and it is here that the experience of the physician counts for much. When properly fitted, *the pessary should never cause any pain or even make the patient*

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conscious of its presence, and it may be worn for years, with certain precautions as to cleanliness, to be mentioned later, without harm.

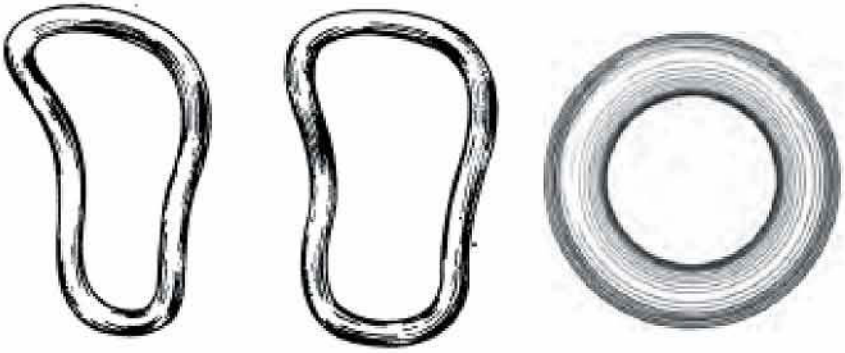

FIG. 829.—Hodge-Smith pessary.
FIG. 830.—Hodge pessary.
FIG. 831.—Ring pessary.

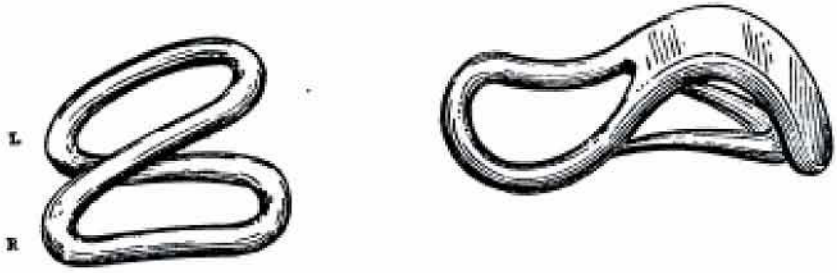

FIG. 832.—Gehrung's pessary.
FIG. 833.—Skene's pessary.

FIG. 834.—Cup or ring (*a*) pessary with external support. (Ashton.)

On the other hand, an ill-fitting pessary or one employed in a case not suitable for such treatment is distinctly harmful. It should, therefore, always be impressed upon the patient that if the least pain

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or an undue amount of leucorrhea results from the insertion of the pessary, she should report to the physician immediately, or else remove the pessary herself.

Pessaries.—Pessaries are made of hard rubber in a great variety of shapes. For retrodisplacements the most commonly employed is the Hodge-Smith (Fig. 829). If, however, the pelvic floor is relaxed, a Hodge pessary (Fig. 830) is preferable, as its wide lower bar renders it less liable to slip out. These act as levers in the vagina in such a way that the force is exerted upon the posterior cul-de-sac and the uterosacral ligaments, so that the cervix is pulled backward and the uterus is thus tipped forward.

Ring pessaries (Fig. 831) are also employed in retrodisplacements where there is not sufficient support for the ordinary pessary. They act by so distending the vagina in all directions that the uterus is supported by the lower vaginal structures. The ring should be smooth and fairly thick, at least 1/4 inch (6 mm.), so as to avoid any danger of its eroding through the vaginal walls. The ring pessary is also employed for retaining a prolapsed uterus in place; but in many cases of prolapse, the perineum is so relaxed that the pessary immediately slips out, and some sort of pessary held in place by an abdominal support, such as is shown in Fig. 834, will be necessary.

For supporting a cystocele Gehrung's anteversion pessary (Fig. 832) or Skene's pessary (Fig. 833) is often used with success.

As previously stated the pessary should be fitted to each individual case. The shape of the pessary may be readily changed by first coating the instrument with oil or vaselin and then softening it by the heat of an alcohol lamp. When it has been moulded to the desired shape it is hardened again by immersion in cold water. The tendency is to employ too large a pessary, which is dangerous, as it may exert undue pressure upon the vaginal wall and produce excoriations, or in time even ulcerate through. On the other hand, if the pessary is too small, it will not remain in place. The safest plan is to measure the vagina in each case and shape the pessary accordingly. The depth of the vagina is determined by carrying two fingers as high as possible into the posterior cul-de-sac and measuring the distance from the inferior border of the symphysis, while the width is estimated by noting the distance to which the two fingers in the vagina may be separated. About 1/2 inch (1 cm.) should be deducted from the former measurement for the correct length of the pessary.

Asepsis.—The ring pessary may be sterilized by boiling, but the others, if so treated, lose their shape; prolonged immersion in some

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antiseptic solution, such as 1 to 500 bichlorid of mercury, should be employed instead.

Position of Patient.—For inserting the pessary the patient is ordi-

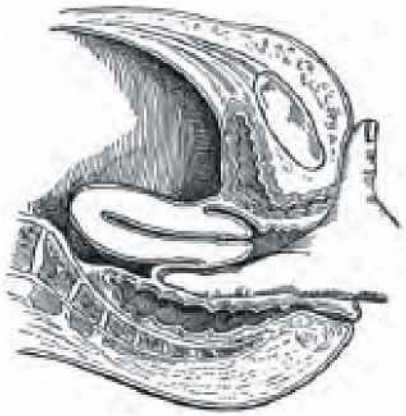

FIG. 835.—First step in replacing a retroverted uterus. (Ashton.)

narily placed in the dorsal posture, though in some cases the knee-chest position may be used to better advantage.

Preparations of Patient.—The bladder and bowels should be empty, and the clothing well loosened.

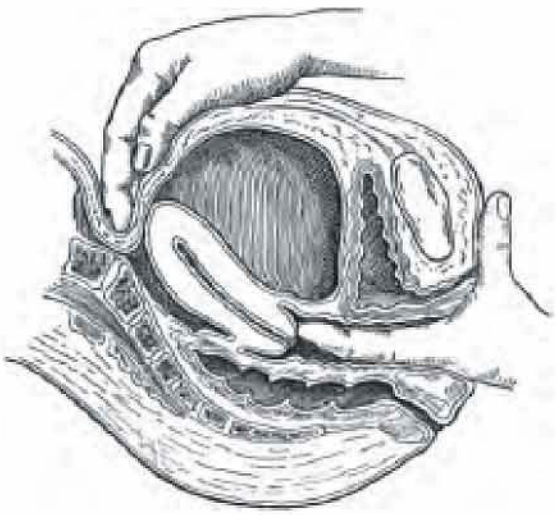

FIG. 836.—Second step in replacing a retroverted uterus. (Ashton.)

Technic.—1. *Replacement of the Retroverted Uterus.*—There are two methods of replacement: (1) By bimanual manipulation, and (2) with the patient in the knee-chest posture. The former method is usually effective if the abdominal walls are not thick and rigid and

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the vagina is sufficiently roomy. It is performed as follows: Two fingers of the left hand are introduced into the vagina and are carried up into the posterior cul-de-sac where they exert pressure in an

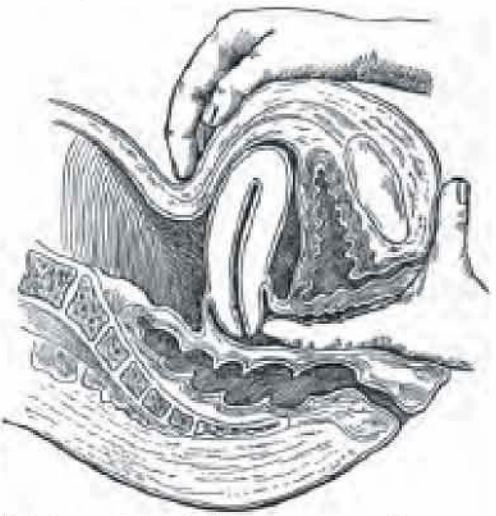

FIG. 837.—Third step in replacing a retroverted uterus. (Ashton.)

upward and forward direction upon the body of the uterus (Fig. 835). As the uterus is thus elevated, the right hand is placed upon the abdomen, and an attempt is made to hook the fingers behind the fun-

FIG. 838.—Second method of replacing a retroverted uterus. First step. (Kelly and Noble.)

dus (Fig. 836). The fundus is then pulled forward by the fingers of the external hand while the internal fingers are shifted to the anterior fornix, where they make backward pressure upon the cervix and the

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lower segment of the uterus (Fig. 837). Sometimes, however, it is not possible to raise the fundus past the promontory by this method. In such a case the anterior lip of the cervix should be grasped in

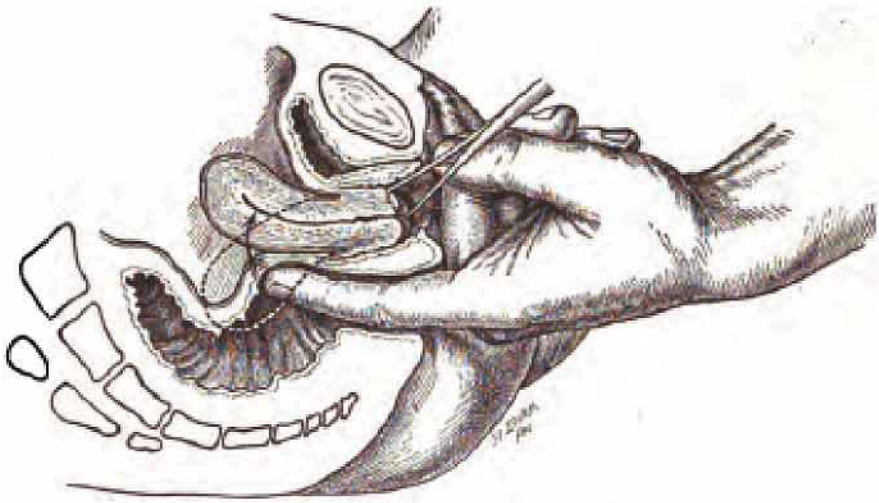

FIG. 839.—Second method of replacing a retroverted uterus. Second step. (Kelly and Noble.)

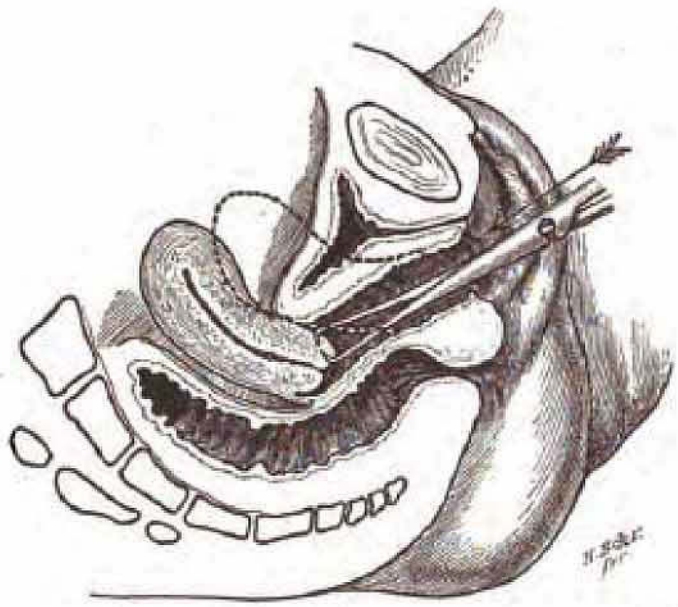

FIG. 840.—Second method of replacing a retroverted uterus. Third step. (Kelly and Noble.)

bullet forceps, and the whole uterus is then pulled down toward the vaginal outlet (Fig. 838). At the same time the index-finger of the left hand covered with a glove is inserted into the rectum and the

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fundus is elevated past the promontory (Fig. 839). The cervix is then pushed backward (Fig. 840), the bullet forceps are removed, and reposition is completed bimanually as described above.

If these manipulations fail, the patient should be placed in the knee-chest posture and the posterior vaginal wall retracted by means of a Sims or Simon speculum. This frequently results in the uterus falling forward through the effect of gravity. If it does not, the cervix should be grasped with bullet forceps and pulled upward and outward toward the vaginal outlet, while the fundus is pushed forward by means of a pair of dressing forceps armed with a pledget of cotton

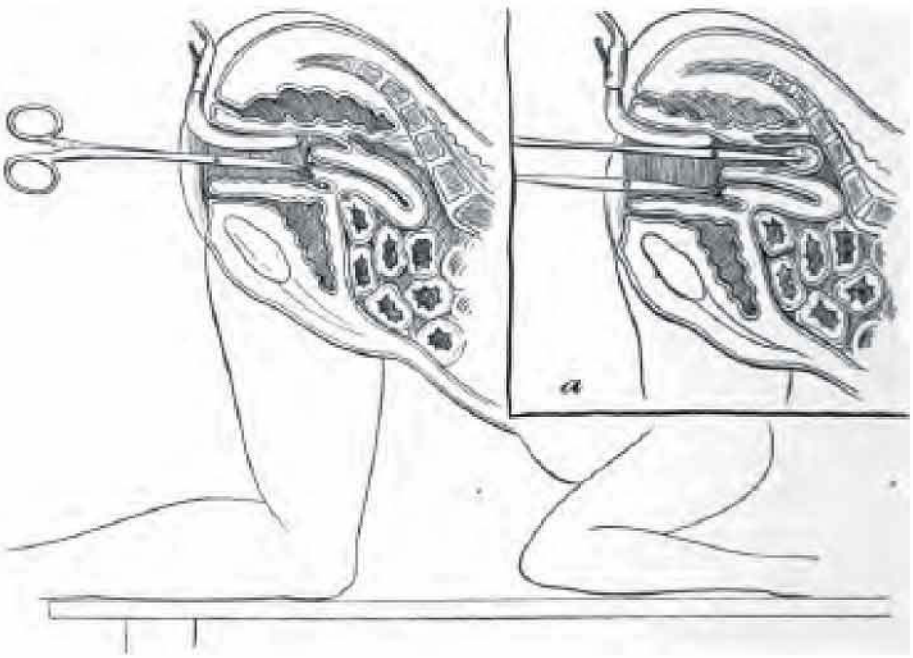

FIG. 841.—Replacement of a posterior uterine displacement in the knee-chest position. Showing the cervix drawn forward and the fundus swinging clear of the promontory. Illustration *a* shows the fundus pushed anteriorly by direct pressure. (Ashton.)

carried up into the posterior cul-de-sac (Fig. 841). The patient is then slowly and carefully turned to the dorsal position, and a bimanual examination is made to determine if the uterus is still in position before a pessary is inserted.

In all manipulations toward replacement of a uterus, the utmost gentleness should be employed. If the patient is very sensitive or the abdominal walls rigid, it is preferable to give a general anesthetic rather than employ force.

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2. *Introduction of Pessaries.*—To insert the ordinary retroversion pessary, the left index-finger is carried into the vagina and the vaginal

FIG. 842.—First step in introducing a retroversion pessary.

wall is retracted, while with the right hand, the pessary is introduced at first obliquely (Fig. 842), and then turned so that it lies transversely

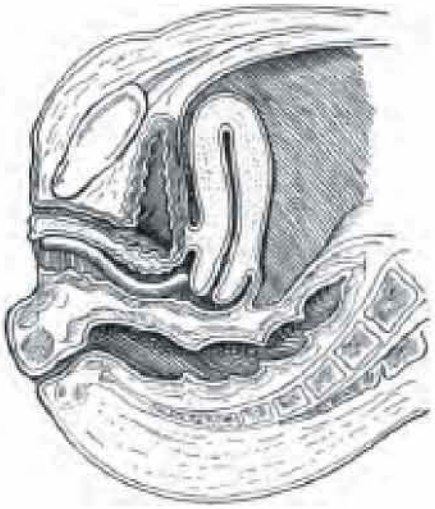

FIG. 843.—Showing the pessary in the vagina with the posterior bar in contact with the cervix. (Ashton.)

in the vagina (Fig. 843). The index-finger of the left hand is then shifted so that it lies under the anterior bar with its tip resting upon the posterior bar (Fig. 844). The posterior bar is then pressed down-

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ward and backward until it lies behind the cervix (Fig. 845). After the pessary has been introduced, the patient is examined while in the erect position to see if it fits properly. A properly fitting pessary

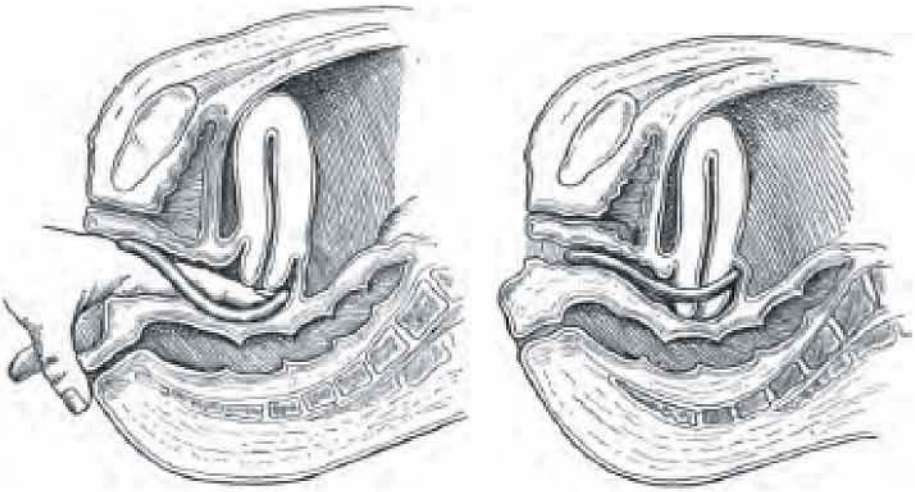

FIG. 844.—Second step in introducing a retroversion pessary, depressing the posterior bar and inserting it behind the cervix. (Ashton.)

FIG. 845.—Showing the retroversion pessary in place. (Ashton.)

FIG. 846.—First step in introducing a ring pessary.

should hold the uterus in place and at the same time should not be so tight that the examining finger cannot be passed between the vaginal walls and the pessary on all sides.

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The ring pessary is introduced in much the same way, that is, the left index-finger retracts the posterior vaginal wall while with the fingers of the right hand the pessary is introduced obliquely into the vagina (Fig. 846). It is then turned transversely and is manipulated

FIG. 847.—Shows the ring pessary in place.

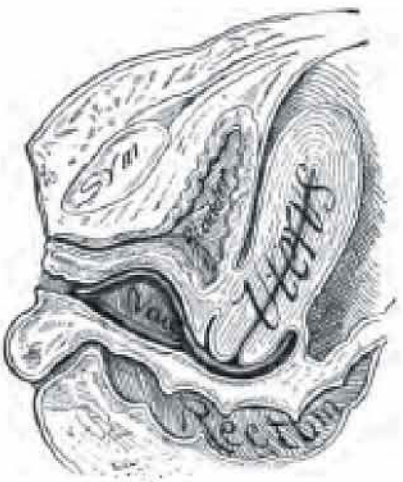

FIG. 848.—Showing Skene's pessary in place. (Ashton.)

by the internal fingers until it lies in proper position with its opening surrounding the cervix (Fig. 847).

Skene's cystocele pessary is introduced into the vagina in the same manner as the retroversion pessary, with the posterior bar lying behind the cervix, and the broad anterior bar supporting the bladder (Fig. 848).

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Gehrung's cystocele pessary is more difficult to introduce. The following method is employed: The pessary is placed upon a table in such a way that it rests upon its inferior arch, with the two curves,

FIG. 849.—First step in introducing Gehrung's pessary.

right and left, facing toward the operator, who then grasps the curve L between the thumb and forefinger of the right hand, and inserts curve R into the right side of the vagina (Fig. 849) and then curve L

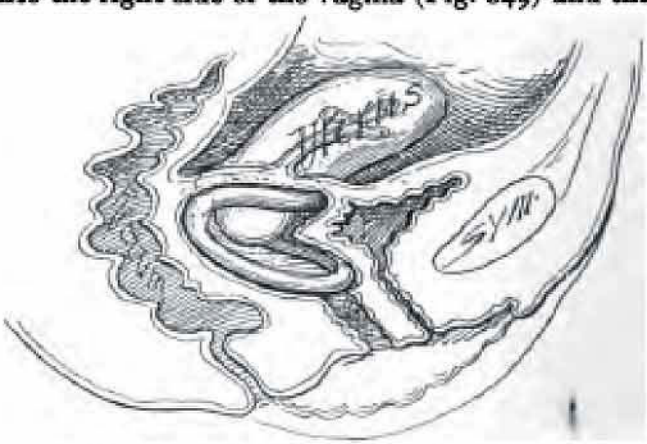

FIG. 850.—Gehrung's pessary in position.

into the left side. The pessary is then manipulated into such position, that the superior arch lies up in front of the uterus, the inferior arch under the pubic arch, and the two curves R and L on the posterior vaginal wall (Fig. 850).

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After-care.—Within three or four days after introduction of the pessary, the vagina is inspected to determine whether there is any erosion from undue pressure of the pessary. The patient is then examined once every month or six weeks, at which time the pessary is removed and well cleansed before re-insertion and the vagina is examined for signs of ulceration, which, if present, necessitate the removal of the pessary and the substitution of medicated tampons until healing has been effected. Once a week and after each menstrual period the patient should take a warm boric acid or soapsuds douche for cleansing purposes, while, if there is irritation from the presence of the pessary, a daily douche should be administered. In cases where the displacement is accompanied by considerable uterine congestion and enlargement, a hot vaginal douche should be given night and morning (see page 771). In all cases the physician should impress upon the patient the necessity of reporting if at any time the pessary causes any pain or discomfort.

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