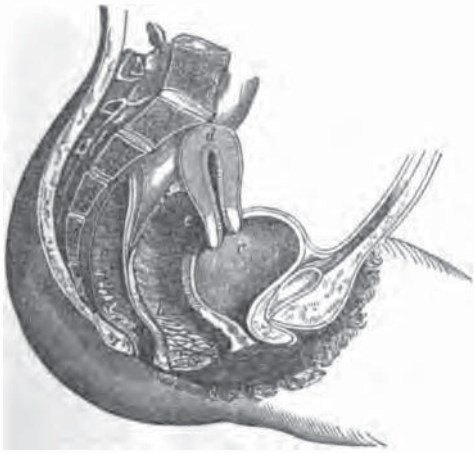
A Case of VESICO-VAGINAL FISTULA *with the Os Uteri closed up in the Bladder; cured.* By J. MARION SIMS, M. D., of New York, late of Montgomery, Ala.

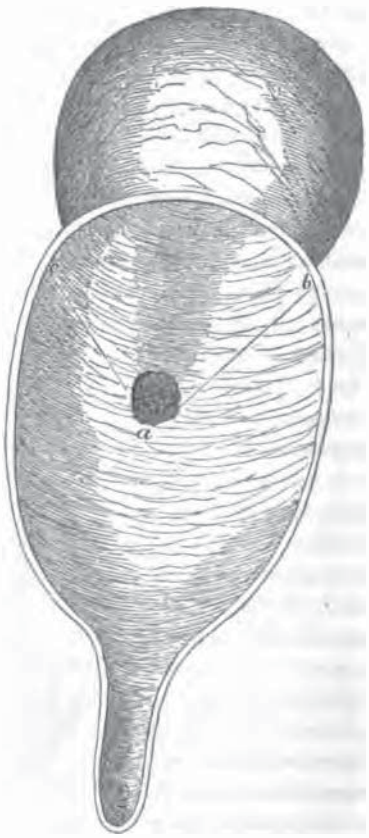
MRS. H., aged 43 years, large and fat, weighing about 180 lbs., the mother of five children, was the subject of vesico-vaginal fistula, which occurred in August, 1842. In labor about 36 hours—the head impacted 12. She was delivered by Dr. Moore, of Wetumpka, Ala., without instruments. Sloughing of the soft parts occurred some 9 or 10 days after delivery. On the 14th, the sloughing process opened the bladder, and she has never been able to retain a drop of water since. After delivery she was seriously ill for a long time. Her physician had but little hope of her recovery, as she was suffering not only from this extensive vaginal disorganization, but also from a violent attack of acute metritis, which rendered her condition truly alarming. She eventually slowly recovered, but was quite an invalid for a long while afterwards. It was two and a half years before the menstrual secretion was reëstablished; after which her sufferings at each period were almost intolerable, being attended with bearing-down efforts, similar to, and quite as severe as, real labor pains, whereby large masses of coagula were forced through the urethra. This is explained by a very remarkable peculiarity, which is I believe, without a parallel.



The accompanying cut is intended to represent the relative position of the parts. The rectum *a*, vagina *b*, bladder *c*, and uterus *d*, which is tilted over backwards with its fundus impacted, almost immovably under the promontory of the sacrum, while the os tincæ is thrown forward under the arch of the pubis, opening not into the vagina, but in the cavity of the bladder, which readily explains the phenomenon above alluded to. The fistula at *e*, just behind the cervix uteri, is barely large enough to admit the end of the index finger. From the fistula back

to the point at *f*, is a large cicatrix, the result of the sloughing, which here, doubtless, did not extend through all the coats of the vagina, while at *e* it perforated the bladder. The vagina was short, but otherwise capacious. This shortening, I suppose, depends mainly on the downward pressure exerted by the retroverted and prolapsed uterus, but in some degree on the loss of substance from sloughing.

The peculiar malposition of the uterus doubtless occurred during the violent metritic inflammation, and when the fistula was large enough to permit the os and cervix to project through it into the cavity of the bladder; after which it gradually contracted during the cicatrizing process, till it was reduced to its present size. Of course, it is not pretended that there was anything singular in the relative position of the uterus, as we are all perfectly familiar with such cases; but that the os uteri should have been incarcerated in the cavity of the bladder, is certainly very remarkable.



In regard to an operation, the first idea with me, as it would have been with any one else, was to liberate the os tincæ from its abnormal confinement, and bring it into its natural position in the vaginal canal. Accordingly I tried the experiment on the 20th of Oct., 1849.

This diagram is to represent a horizontal section of the vagina, with the posterior face of the uterus visible above it, *a*, the fistula, through which a uterine sound slightly curved can be passed into the os and cervix uteri. Freshening the edges of the fistula, I made two incisions from it through the coats of the bladder, upwards and outwards, in the direction of the lines *a*—*b* and *a*—*c*. I then passed Simpson's sound into the uterus, and using it as a lever, lifted the cervix into the vagina, where I intended to hold it till the fistula could be closed on the opposite side; but I was foiled completely. The almost unbearable pain resulting from the

section of the bladder at its junction with the cervix uteri, and the no less painful state arising from the efforts to force the uterus into its proper place, all produced such a distressing involuntary bearing down, that the operation could not be proceeded with. The parts were entirely obscured, the vagina being thrown into numberless folds, and the instruments (lever speculum and uterine sound) displaced and forced out, despite of operator and assistant. The patient insisted that it was impossible for her to bear the operation; and I now saw that there was a physical barrier to its completion, even if she had the moral fortitude to undergo it. What then was to be done? Why, there was no alternative but to close the fistula, leaving the uterus confined in its old and unnatural position. There were good reasons for this.

1st. The catamenia would probably commingle with the urine, and be discharged as bloody water, instead of coagula as now, which would certainly render her condition altogether preferable to her present state.

2d. As she was now 43 years old, and as the catamenia had been getting more scanty for the last two years, it was probable that they would soon cease entirely.

3d. The catamenia were now expelled in immense coagula through the urethra, and her condition could not be made worse.

The fistula was closed by the *clamp suture*, composed of two silver wires, passed transversely, and secured in the usual way. Unfortunately, one of the wires broke, close to the shot, just as I was in the act of masking it. Out of upwards of ninety operations performed in my experiments on the treatment of this affection, in the last eight years, this is the only instance in which this accident has happened. But as patient, assistant, and surgeon, were all worn out, I concluded to trust something to luck, and did not replace the broken suture.

Mrs. H. was doing well, till the 4th day, when she had a terrible chill, lasting some three hours, followed by fever and delirium, which, she says, is always a concomitant of fever with her. Besides this, she vomited almost incessantly for about 12 hours. On the next day, at 5 P. M., Mrs. H. informed me that the operation was a failure. I was not surprised to learn this, for I feared that the constant vomiting would burst loose the upper ends of the clamps, which I had failed to fasten properly, but I was greatly surprised that my patient was the first to make the discovery. She acknowledged that she had removed the catheter daily, keeping it out for an hour or more, just to see if the bladder retained urine, when she would reïntroduce it herself.

An examination showed the shot slipped from the broken wire, the clamps open, and the fistula reproduced. But for this unlucky accident, there is every probability that the opening would have been closed by a

single operation. The suture apparatus was removed, the patient turned loose, and put on a generous diet preparatory to a repetition of the operation. This was done on the 7th Nov., which was entirely too soon, for the parts had not acquired a sufficient degree of strength and toughness to bear the tension and pressure of the suture apparatus. But she insisted on the repetition of the operation, alleging poverty as the great hastening motive. The fistula was closed by two sutures, passed antero-posteriorly, and clamped in the usual way. Before the operation was finished, I discovered that I had not selected the most judicious method for it. Fistulas near the cervix uteri are always more difficult to cure than those lower down. In this case, as in all similar ones, the anterior edge of the fistula was formed by the free border of the *bas-fond* of the bladder, while the posterior was composed of the firm, inelastic, cicatricial tissue, which had to be dissected from its attachments, to form a flap through which the distal ends of the sutures were passed. Thus the anterior edge of the fistula was thick, tough, and yielding, while the posterior was thinner, not so elastic, and, therefore, more easily cut through by the sutures. Notwithstanding this unfavorable condition, made worse by the too early repetition of the operation, the parts united and the fistula was evidently healed.

The suture apparatus was removed on the 6th day after the operation. The urine was retained perfectly and passed spontaneously, but, unfortunately, I did not then know how long it was necessary for the clamps to remain, to insure a consolidation of the cicatrix. They were removed too soon, by half, and, of course, the cicatrix gradually gave way, and the fistula was reproduced, to the great mortification of all parties. Instead, however, of being large enough to receive the end of the finger, it would now barely admit a good sized probe.

On the 5th Dec. the operation was repeated—the sutures passed transversely. The clamps were removed on the 9th day, which was too soon for safety. She was kept in bed—the catheter in the bladder—for several days longer, and the operation was entirely successful.

The catamenia, as anticipated, appear now regularly at the stated periods, commingle with the urine, and pass off as bloody water; thus, she was not only cured of the disgusting affection, fistula, but also relieved of her dreadful monthly sufferings.

The case, take it all in all, is unique, and I think instructive.

79 MADISON AVENUE, NEW YORK,
Nov. 23d, 1853.