Treatment of Retro-Displacement of the Uterus.*

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Before approaching the question of treatment it would be well to ask if retro-displacements always cause symptoms which necessitate treatment? The answer in my experience should be that as a rule sooner or later symptoms occur. These are menstrual disturbances, abnormal discharge, pains and aches, sterility. I am aware this opinion does not agree with that of Herman and most other English writers, but "I give you the tale as it has been told to me."

Next—what are the causes which produce retro-displacement? One must have a clear conception of these in order to apply treatment intelligently.

The most common are those arising from conception which has ended in an abnormal manner, and thus led to the injury and subinvolution of those structures which maintain the pelvic organs in position.

The next most frequent is improper mode of living, especially during the developmental period of life. At this time exercise associated with full rectum and bladder strongly tends to produce displacement, as do also excessive mental efforts, which impair health and divert vital energies required for the vigorous development of the genital system to another and less important purpose.

Coming now to the all-important question of *treatment*, it is evident from the frequency and warmth of the discussion on the subject throughout the world that this is far from settled .

Purely Hygienic.

Manipulative (Massage).

Mechanical (Pessary).

Operative (in which the procedures recommended are many and various) all have strenuous advocates.

Hygiene is always wise, and when there are no symptoms should be the treatment of choice.

Pelvic massage has fortunately few followers.

Pessary treatment is still largely used, and does incalculable harm. Everyone who has studied the bacteriology of the vagina and realised how readily the normal flora become pathogenic must admit this. Pessaries necessarily produce stasis of the vaginal and uterine secretions, and stasis inevitably leads to infection. This is seen in all the excretory canals throughout the body—tear ducts,

* Being the opening of the discussion on this subject at the Australian Medical Congress in Auckland, New Zealand, February 11, 1914.

biliary ducts, urethral canal, intestinal canal, genital canal. It is far better to do nothing than adopt a treatment which interferes with nature; wherefore I think the pessary treatment should be discarded.

Operative Treatment.—I have looked through my records for the past five years, and find that during that time I have done *the Webster-Baldy operation* of passing the round ligaments through the broad ligaments and suturing them behind the uterus ten times with no mortality and one failure. It seems to me this procedure obstructs the broad ligament veins, but I am not disposed to condemn it without a larger experience.

The Original Alexander's Operation.—Seventy-two times with no mortality and seven failures or relapses. I find I am gradually doing this operation less frequently, although I still consider it is the best operation for uncomplicated retrodisplacement in young or middle-aged women. In the old or emaciated, or those in whom there has been procidentia for a long time, the round ligaments become so attenuated as to be of little value; also, I so often recognize probable appendicitis or indication of salpingitis, shortening of the broad ligaments, or abnormal size of the uterus that the tendency is to decide in favour of an intraperitoneal operation.

Five times I have done *abdominal section* plus *Alexander's operation* by making a "T" incision of the medium incision, thus reaching the external abdominal rings. These cases did well. One could note the exact effects of shortening the round ligaments in the position of the uterus. The extra time is against this procedure, and also the feeling that when the peritoneal cavity is open it is better to adopt the method that gives the most certain results.

I have never known Alexander's operation to cause the slightest trouble during pregnancy or labour except in one case operated on by another surgeon in which there was great pain in the inguinal canals during the pregnancy, necessitating the induction of labour in the seventh month. I think the ilio-inguinal or genito-crural nerves must have been included in the non-absorbable sutures. Why Alexander's operation occasionally fails, even when done in apparently suitable cases, I am unable to determine.

There have been 334 ventrosuspensions in the five years; of these 191 were primary and 143 secondary—that is, 143 were done in the course of an operation for some other condition, and the other primarily for retroversion associated with one or other of the conditions which I have mentioned above as excluding Alexander's operation.

The mortality was nil in the primary and one in the secondary. There were five relapses at an early date apart from pregnancy and three after labour. On the other hand, in six cases the uterus was found to be normal in position a variable period after labour. Preg-

nancy and labour at term occurred eleven times without unusual trouble of any kind. Abdominal section was required subsequently to ventrosuspension in thirteen cases as follows:—

For *Ectopic Gestation,* band 1½ inches long.
Myoma, band 4 inches long.
Acute Gonorrhœal Salpingitis, band 2½ inches long.
Acute Salpingitis, band 1 inch long.
Ectopic Gestation, after normal pregnancy had occurred; uterus normal in position, no trace of band.
Retroversion after two operations for the same at other hospitals; band like a piece of twine, 6 inches long from posterior surface at level of inner os.
Adeno-myoma diffusum, band 1½ inches long.
Adeno-myoma diffusum, band 1½ inches long.
Appendicitis, band 2 inches long.
Retroversion, for recurrence, no band.
Appendicitis, band 1½ inches long.
Oöphoro-Salpingitis, band 2 inches long.
Appendicitis and adhesion of sigmoid to stump of left tube removed at previous operation, band 2 inches long.

In no case did these bands exceed half an inch in width; most were less than this.

I have heard of two other cases in which my colleagues operated for relapses subsequently to labour, the original operations having been performed by me, in which there were long useless bands.

I wish to emphasise that all the above figures refer only to cases which have come under my notice, and that it has been quite impossible for me to have discovered the subsequent history of the cases as a whole.

I have never seen or heard of any ventrosuspension done by myself giving rise to either dystocia or intestinal obstruction. One patient was sent into the Sydney Hospital with the diagnosis of obstruction due to ventrosuspension. Operation showed that the obstruction was due to a Meckel's diverticulum, and in no way connected with the ventrosuspension band.

The procedures grouped under the term *ventrosuspension* are so many and so varied that it conveys no exact meaning without full details of the technique.

On the one hand you have a surgeon, as in one of the above-mentioned cases, seeking to unite the posterior surface of the uterus at the level of the inner os to the parietes. While others avoid the posterior surface and obliterate completely the utero-vesical space by uniting the whole of the anterior surface of the uterus to the serosa of the bladder and parietes.

Each dubs his method ventrosuspension, although in the latter of these methods the uterus is really fixed by its anterior surface.

In the discussion on the treatment of malpositions of the uterus, at the last meeting of the B.M.A. at Brighton, Dr. Mary Scharlieb opened the discussion, and described her technique as "passing three silk worm-gut sutures through fascia and peritoneum on one side, then through the musculature of the uterus as low down as possible on its anterior surface, then through fascia and peritoneum on the other side" (it would be interesting to follow the subsequent history of these buried, non-absorbable sutures in close contact with the bladder). She says: "I have never placed the suture in the fundus itself, still less have I invaded its posterior aspect."

Drs. Giles, Martin, and Cuthbert Lockyer agreed with the technique, and all expressed belief in pessaries. Mrs. Scharlieb in her reply said: "It could not be too strenuously insisted upon that no fixation sutures should be passed in the fundus or posterior wall of the uterus."

I say the exact opposite. It cannot be too strongly insisted upon that no suture, and especially no non-absorbable suture should be passed through the anterior wall of the uterus.

My reasons are that the uterus has no normal fixed *position*, but a normal *range of movement*. Sutures of silk worm gut passed as described by Mrs. Scharlieb must necessarily fix the uterus. Secondly, sutures passed through the anterior wall must necessarily throw the uterus backwards to some extent, and thus invite intra-abdominal pressure to exert its force on the anterior instead of the posterior surface, as intended by nature.

The purpose of the various ligaments, round, broad, and utero-sacral, is, conjointly with the pelvic floor, to utilise the greatest, and what one would imagine to be the most disturbing force—intra-abdominal pressure—as the chief means of maintaining equilibrium. These ligaments—guy ropes, as they have been called—ensure that the posterior surface of the uterus shall be exposed to intra-abdominal pressure, so that the greater the effort the more certainly is the uterus pressed forward against the pubes, while at the same time the pelvic floor, acting synchronously with abdominal strain by pulling the posterior segment of the floor forwards against the anterior, deflects the force in a harmless direction.

If these views are correct, we should avoid any method by which the anterior uterine surface is exposed to intra-abdominal pressure, and Mrs. Scharlieb and her supporters must be held to be wrong.

The object to be attained is to restore the integrity of the damaged guy ropes by Alexander's or similar operation, or, if it seems best, to create a new guy rope by the ventrosuspension technique, which I shall describe, while at the same time, if necessary, the pelvic floor is reconstituted so that it can carry out its important function.

The technique adopted in all the cases to which I have referred is as follows:—

The fundus uteri is seized with volsellum forceps in the centre, about one line behind the level of insertion of the tubes; a round, curved needle, with No. 3 ordinary catgut, is passed through the fascia and peritoneum of one side the musculature of the uterus at the point gripped by volsellum and peritoneum and fascia of the opposite side. A similar suture is passed about quarter to half an inch posterior to this. The serosa of the quarter square inch, just behind the summit of the uterus included in these two sutures is then carefully abraded, and, by tying the two sutures, brought in contact with a similar abraded raw area on the parietal peritoneum.

This operation is easy, safe, and gives a symptomatic anatomical and physiological cure in 90 per cent. of cases; that it does this, and also that it in no way interferes with pregnancy or labour, I think my cases fairly prove. True, the guy rope is either destroyed or rendered useless by pregnancy, but if all has been normal in the puerperium nature's apparatus will probably have been restored, and there will be no need for further help, as has been clearly shown in several of my cases. However, in order to meet this drawback to a ventrosuspension operation, I have for the past year accepted the suggestion of Murphy, of Chicago, and drawn the round ligaments over and sutured them behind the tubes at the posterior surface of the uterine cornu before tying the ventrosuspension sutures, thus giving a reinforcement to the latter capable of evoluting and involuting.

In the *A.M. Gazette* for January 24th there is an able résumé of "The Effects on Labour of Ventrofixation," by Dr. S. Harry Harris, of Sydney, who adds two cases of his own in which dystocia occurred after ventrofixation and Gilliam's operation respectively. Dr. Harris refers to a number of reported cases in which serious consequences at labour followed the operation, but, as I said before, I restrict my remarks to my own experience, of which I give you an unvarnished tale. It is evident that in many of the cases collected by Dr. Harris suppuration occurred, and of the others we do not know the exact technique adopted.