The Use of a Hodge Pessary for Correcting Backward Displacement of the Uterus*

BY

T. N. A. JEFFCOATE, M.D., F.R.C.S., F.R.C.O.G.

Professor of Obstetrics and Gynaecology, University of Liverpool.

ALTHOUGH it is generally agreed that a mobile retroversion or retroflexion of the uterus is usually symptomless, its correction as a temporary measure is sometimes indicated for purposes of diagnosis, during early pregnancy or the puerperium and in cases of infertility, etc.

In such circumstances it is usually taught that the position of the uterus should be first corrected by bimanual manipulation as a temporary measure is sometimes volsellum, and that thereafter the position of the uterus should be maintained by inserting a pessary. The best pessary for this purpose is probably the Hodge, or one of its modifications; a ring is not so satisfactory but may have to be used if the retroversion is associated with prolapse or a defective perineum. However, reposition of the uterus by the accepted method is not so easy a procedure as it appears, and is as a rule beyond the capacity of anyone without special experience and training. Indeed, many gynaecologists often find it necessary to resort to general anaesthesia in order to perform the manoeuvre, especially in nulliparous women. The secret in any case is to manipulate the cervix rather than the body of the uterus itself. One of the difficulties is that the uterus is not always within easy reach, moreover it may return to its former position when the operator removes his fingers to pick up the pessary for insertion.

It is now well established that in the comparatively rare cases in which an impacted retroverted gravid uterus does not correct itself spontaneously, and cannot be replaced, a useful procedure is to insert a large-size ring pessary, and the continuous pressure causes a gradual correction of the position of the uterus. The object of this note is to point out that in all cases, no matter whether the woman be pregnant or otherwise, the easiest way to correct retroversion or retroflexion is to do it with the pessary itself. The pessary, however, is used as a lever on the cervix and not as an agent for exerting pressure on the fundus as in the case of the impacted uterus mentioned above.

Procedure.

With the patient in the left lateral position and the uterus still retrodisplaced, a suitably sized Hodge pessary is inserted and allowed to take up its own position. It will be found that the upper rim naturally comes to lie in the anterior fornix, the lower bar projecting just beyond the introitus (Fig. 1). One or two fingers are then inserted behind the lower bar, through the pessary and in front of the upper rim. Pressure is exerted backwards on the upper end, which is pushed against the anterior aspect of the cervix (Fig. 2). If the upper end of the pessary is out of reach the fingers

* Read before the North of England Obstetrical and Gynaecological Society, 4th July, 1947.

can be placed on anterior aspects of the side bars as high up as possible. With continued pressure the cervix is deflected backwards and the body of the uterus begins to rotate forwards. Ultimately the upper end of the pessary slips past the cervix into the posterior fornix and into its correct position (Fig. 3). By this time the retroversion is nearly always automatically corrected. Sometimes it is only partially corrected, the uterus lying with its axis vertical. In such cases the upper end of the pessary is pushed firmly against the posterior vaginal wall just behind the cervix, and the posterior fornix "stroked" backwards and slightly downwards with the pessary (Fig. 4). At the same time the lower end of the Hodge comes to lie at a higher level against the anterior vaginal wall. The cervix is thus levered further backwards, the fundus uteri comes forwards, and the pessary is at the same time left in its proper place.

There is a knack in carrying out the operation, but once it is learned the method is extremely simple and can be carried out without much experience. I have rarely known it to fail except when the uterus is fixed by adhesions; indeed, it can be employed as a test of mobility. Except in the case of virgins it is never necessary to administer an anaesthetic. The manoeuvre causes the patient such little disturbance that she does not realize that it has been carried out. One of the advantages of the technique is that it does not involve any pressure on the body of the uterus and it can be applied during early pregnancy, even in patients who habitually abort, without any risk of causing an abortion. Indeed, it is so easy, painless and safe that there is much to be said for using it as a routine when a retroverted gravid uterus has not corrected itself by the 8th or 10th week, rather than take the admittedly small risk that the uterus will become

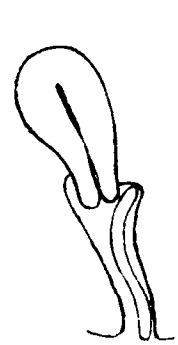

FIG. 1.

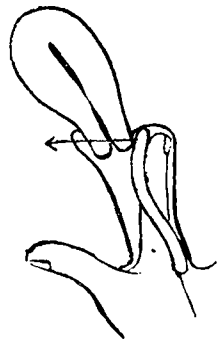

FIG. 2.

FIG. 1.
Insertion of Hodge pessary with uterus in position of retroversion. The upper end of the pessary comes to lie in the anterior fornix.

FIG. 2.
One (or two fingers) inserted through the pessary, the upper end of which is pressed firmly backwards against the cervix.

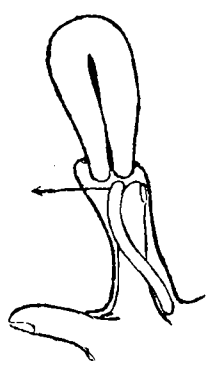

FIG. 3.

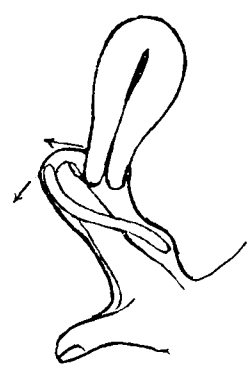

FIG. 4.

FIG. 3.
As cervix moves backwards and fundus begins to rotate forwards, the upper end of pessary slips behind the cervix into posterior fornix.

FIG. 4.
If uterus is not already in good position, anteversion is increased by pressing the upper end of pessary further backwards and slightly downwards. The cervix is thus pulled backwards by putting tension on the posterior vaginal wall and the overlying tissues.

impacted. The method is also useful in the puerperium, when tenderness of the vaginal walls and perineum may make the usual manipulation both difficult and painful. If the vaginal walls and perineum are atonic, however, a Hodge pessary may not be retained and a ring pessary is necessary. The same technique can be carried out with a ring, but it is perhaps not quite so efficient.

The manoeuvre whereby the pessary is slipped from the front to the back of the cervix as recommended here is by no means original. It is described in most textbooks, both new and old, as a standard procedure *after* manual replacement of the uterus. The suggestion here is that it should be carried out *before* replacing the uterus and as a means of replacement.