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## IMPROVED VAGINAL TOUCH.[1]

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BEFORE entering upon the description of this method, I shall, for the sake of comparison, give a synopsis of the vaginal touch as hitherto practised and described. Thus:[2]

"The index finger of one hand being introduced into the vagina . . . the cervix should be examined with reference to location, size, and density. This being done, the finger should be slid along its posterior surface into the recto-uterine space, and the presence of any hardness or tumefaction there noticed . . . This space being explored, the finger should then be passed anteriorly, and swept upward and forward along the base of the bladder toward the symphysis pubis, etc. . . .

"One maneuvre, by which touch of the parts lying closely in contact with Douglas' cul-de-sac is much facilitated, still remains to be mentioned. Where small tumors exist behind and disconnected with the uterus, or where enlarged or prolapsed ovaries are to be sought for and examined, an excellent result is often obtained by placing the patient in Sims' left lateral position, and passing the index and middle fingers of the right hand as high up as possible, their palmar surfaces looking toward the posterior wall of the vagina. By this method I have repeatedly detected enlarged and slightly displaced ovaries, which in the dorsal decubitus had entirely escaped observation."

Throughout gynecological literature I find the description of the vaginal touch essentially the same as the foregoing. Therefore I shall not add more quotations.

The information gained by this procedure, without the assistance of conjoined manipulation, rectal or vesical explor-

[1] Read before the St. Louis Obstetrical and Gynecological Society, June 20th, 1878.

[2] Thomas on the Diseases of Women, p. 61 et seq.

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ation, is very unsatisfactory, and yet there are many cases where none of these auxiliaries can be used. In such cases, and as a substitute for the ordinary vaginal touch, I use the following maneuvre wherever applicable:

The patient being placed in the dorsal position on a table (prepared as usual), the heels touching the outer side of the nates, and the knees separated as far as possible, to shorten the depth of the perineum, introduce two fingers if possible, and make out the probable diagnosis as by the ordinary touch. This should be well recorded mentally. Then, by elevating the cervix, *so as to increase or exaggerate the probable deviation of the womb*, sustain it (the cervix) in that exaggerated position by one finger and let the other feel about in the direction where the fundus is supposed to be, according to the previously-made diagnosis, plus the increased deviation.

For instance, suppose that the cervix is tilted up in the posterior vaginal fornix; if you elevate it still higher in that direction by one finger, the other or searching finger will reach the now considerably depressed fundus with great facility in the anterior fornix, if anteversion be present; if no such tumor is found in that locality, it cannot be anteversion, but probably it is a retroflexion. If now the cervix is pulled forward and elevated toward the anterior fornix as high as possible, the fundus uteri will descend posteriorly to within easy range of the free or examining finger, and the whole posterior wall can now be touched with great facility from os to fundus, and the degree of flexion determined by the depth and position of the sulcus between the neck and body.

On the other hand, suppose the cervix pointing to the symphysis pubis, elevate it still higher toward the anterior fornix, and if you have to deal with a retroversion, the corporeal tumor will soon appear within reach of the unemployed finger, and the posterior wall of the womb is offered for convenient examination, when the size and shape, the presence or absence of tumors may be easily recognized.

If, under these circumstances, the tumor (the body of the uterus) should fail to make its appearance, then you have in all probability an anteflexion before you. By elevating the cervix now into the posterior fornix, the fundus will be pushed

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down between the symphysis pubis and the examining finger, when the anterior wall is as completely exposed to exploration as in the previous case the posterior. Length and breadth of the organ, position and degree of flexion, sensibility, and presence or absence of tumors, can without difficulty be recognized. More than that, the thickness of the organ can also be defined, since the uterus is fixed between the finger and the sacrum on the one hand, and the finger and the pubes on the other. The distance of these fixed points from the finger need not be guessed, but may be accurately measured by alternately touching the body of the uterus, and by the sides of it the pubes or sacrum, as the case may be.

In anterior displacements, it is of great advantage to enlarge the pubic resistance by the application of the free hand to the hypogastric region, even if the abdominal walls are too thick for conjoined manipulations.

There are cases of retroversion which cause considerable inconvenience to the patient, and yet will generally escape detection, because they are temporarily rectified as soon as the finger or the speculum is pressed into the posterior fornix. Nevertheless, this deviation may be easily recognized, by simply pushing the uterus by one or both fingers applied against the os in the direction of the promontory of the sacrum. If retroversion is present, the movement is quickly arrested by the fundus uteri striking against the promontory. If there is no resistance offered, retroversion may almost positively be excluded, because the deviation of the womb is then insufficient to let the fundus reach below the promontory of the sacrum. A deviation of the uterine axis that does not throw the fundus below the promontory cannot be regarded as a retroversion, although predisposing to it.

These exaggerated malpositions enable us frequently—besides the advantages just explained—to investigate the Fallopian tubes and the ovaries (whether prolapsed or not), which are brought within easy range, and which, resting on one side against a resisting medium (the sacrum or pubes), can be palpated or examined much more thoroughly than when floating among the intestines.

Early pregnancy in suitable cases can be diagnosticated much easier than by the usual methods, and we may frequently

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be enabled to state with certainty, that, if pregnancy exists at all, it is intrauterine, and possibly also an extrauterine fetation may be recognized with greater facility than by the usual means.

This mode of touch is not applicable, or, at least, does not give such satisfactory results in all cases, but it has the advantage that it does not preclude any other mode of examination from being used, either in conjunction or subsequently, and that it neither injures nor hurts the patient, and needs no preparation nor anesthesia. Further, that it can be used where all other modes may be inapplicable, and that it is not more objectionable than the simple vaginal touch.

Rudeness in this as well as in any other kind of manipulation is to be highly deprecated.

In the presence of acute pelvic inflammatory diseases, extensive inflammatory adhesion, implication of the uterus or appendages in large tumors, or advanced pregnancy, this maneuvre is either inapplicable or without advantage. It would appear à priori inapplicable in virginal patients, where but one finger can be introduced, but with practice that one finger may be taught to execute, to a greater or lesser extent, the whole maneuvre.

It may be objected against this method that the uterine deviations diagnosticated by it are also caused by it. But if you bear in mind that the probable position is made out beforehand and mentally recorded, this serves merely as corroboration or contradiction of the previous impression.

It may also be supposed that this necessitates a prolonged examination, while, on the contrary, it saves time.

In those cases where abdominal palpation is unsatisfactory or impossible, on account of the presence of abdominal dropsy or large tumors, by the means under consideration we may frequently be able to decide positively whether the womb is or is not implicated in the tumor, and whether there is or is not a probability of pregnancy complicating it. If it can be turned over, more or less completely, and examined, it may be conclusive evidence that it is not implicated, and that there is no advanced pregnancy present. If it is not applicable in all cases, it simply shares this defect with all other methods. When applicable, it may give as good information as the

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rectal exploration or the vesical touch, without the inconveniences and disadvantages of these. The finger is separated from the object to be examined only by the thickness of the vaginal wall.

To avoid being misunderstand, I shall state that I do not offer this plan of examination as a substitute for either of the older methods, but simply as an addition to the usual means of diagnosis.

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