THE MANUAL TREATMENT IN GYNECOLOGY.[1]

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In 1880, A. Reeves Jackson read an able paper on "Uterine Massage" before the American Gynecological Society.[2] Although aiming at the same purpose, the procedure described by him differs materially in many respects from the later methods.

Owing to the investigations and writings of Profanter and Schultze,[3] Resch,[4] Seiffart,[5] Schauta,[6] Von Preuschen,[7] Theilhaber,[8] Lindblom,[9] and others,[10] the manual treatment of diseases

[1] Read before the N. Y. Academy of Medicine, Obst. Sec., April 25th, 1889.

[2] See Gynec. Transactions, Vol. V.

[3] Die Massage in der Gynäkologie, Vienna, 1887. Subsequently another monograph on Procidentia, by Profanter.

[4] Centralblatt f. Gyn., 1887, No. 32.

[5] Die Massage in der Gynäkologie, Stuttgart, 1888.

[6] Ueber gyn. Massage, Prager med. Wochenschr., 1887, No. 43.

[7] Centralbl. f. Gyn., 1888, Nos. 13 and 30.

[8] Münchener med. Wochenschrift, 1888 Nos. 27-28.

[9] Ibid., Nos. 46-47.

[10] Brandt's "Gymnastiken," etc., etc., Stockholm, 1884, has been abstracted and remodelled in German by Resch, Vienna, 1888.

of the female pelvic organs according to the method of Thure Brandt is beginning to find numerous followers, and it is due to their favorable criticism that the time for ridicule is gradually passing. I, too, influenced by published articles, visited Brandt, who, with his accustomed liberality, gave me opportunity to study his method and practise under his supervision. I was the first physician from America to come to him, but I trust that others will soon follow and learn the method from the originator. To him and his former pupil, Dr. Oscar Nissen, of Christiania, I take the opportunity to express my sincerest thanks publicly for the courtesy shown me and the valuable instruction given. Brandt has employed his method as a specialty in gynecology twenty-eight years, and by his practical demonstrations and his willingness to teach others has rendered the profession a service which deserves lasting gratitude.

The treatment, however, requires much time and patience and a very exact practical knowledge of physical gynecological diagnosis; those not possessing the latter should leave it alone, lest they do more harm than good. It is a serious mistake for any one to think that the method can be easily learned, especially from reading.

I fully coincide with Prof. Schauta that to learn it properly one must see the originator or one of his pupils, and receive *practical* instruction from such source; more can be learned in one month by that than in one year otherwise.

To criticise the manual treatment of Brandt so unfavorably as has been done by some, is very unfair, and only those who have *never* used it, or are *practically* ignorant of its *proper* application and the selection of cases suitable for it, have been and can be guilty of such error.

There is, however, a reason why Brandt himself attains more satisfactory results in a shorter space of time than some of his followers—namely, he does not rely on local treatment alone, but subjects his patients to the particular movement cure suitable for the respective case, which in the greater part coincides with the work of his former teacher, Gabriel Branting,[1] he himself adding or changing such as his long experience of forty-seven years had taught him most appropriate.

The patient is invariably first examined while standing, this

[1] See "Die Heilgymnastik." By Dr. A. C. Neumann. Berlin: edition of 1852.

position showing the relation which the uterus bears in the pelvis while walking, better than otherwise; after this she takes her position on the examining lounge, the corset being loosened, or better taken off, and the clothing about the waist also loose. The lounge is short and low, with a rather high and slightly slanting head piece, so as to better accommodate the raised position of the back, shoulders, and head. The patient lies perfectly relaxed in semi-prone position, with the thighs and legs flexed, and the physician takes his seat to her left side, and allows her to rest the left hand and forearm on his right thigh. The left index finger is now passed under the left thigh into the vagina; the hand is slightly flexed at the wrist, and the last three fingers are kept straight and rest on the perineum, instead of being closed as is usually done; the thumb is held abducted and rests on the pubis. The hand used for vaginal examination, held in the manner indicated, has the advantage that the examining finger can be introduced fully one-quarter of an inch deeper, with full mobility, without causing the patient to feel uncomfortable from pressure of the knuckles. The great advantage to be gained by rectal examination in many cases must not be lost sight of. There must not be the slightest exposure of the patient at any time during examination or treatment; this some who have spoken unfavorably of the method do not seem to comprehend, because stress has been put by them on the exposure to which patients are subjected. The right hand and arm, on account of its superior strength generally, is used for external manipulation. The hand is held stiff for massage proper, making all movements from the shoulder and elbow joints, and the palmar surfaces of the first two finger joints are used on the abdominal surface. For diagnostic purposes the manner of holding the external fingers varies. It is of course to be preferred to be able to use either hand with equal ability. We endeavor to obtain the condition and relation of all the pelvic organs with as gentle manipulation as possible. It is, however, very difficult and sometimes impossible to do so the first or the first few times if the abdominal walls are stiff or very adipose, and occasionally we may fail altogether if either or both conditions are in excess.

Having made our diagnosis, the treatment is decided upon, which is divided into the special and general; the latter serves

as an aid to the local and special treatment, and should never be used directly after meals, and the bowels and bladder should always be evacuated as shortly as possible before it is commenced. The general treatment I will not consider in this paper.

Before beginning with the local treatment of the diseased part, a sort of preliminary massage is used, consisting of small circulatory stroking movements, which are begun about the promontory of the sacrum, extending down as far as possible along its anterior surface, with a view to stimulate the lymphatics, which are in greater number here. This initiatory massage I have seen invariably used by Brandt and Nissen, and have also held to it. After this the treatment of the diseased part is commenced; but before entering into the special forms of local treatment, I will mention the indications and contra-indications.

INDICATIONS.

1. Chronic and subacute para- and perimetritis.
2. All non-acute inflammatory conditions of the uterus.
3. Chronic and subacute oöphoritis.
4. Catarrhal salpingitis.
5. *All* displacements of the uterus, with or without adhesions, with restrictions in the treatment if dilated tubes are present, or suspected to be.
6. Recto- and cystocele.
7. Uterine hemorrhages not dependent upon neoplasms in the substance or interior of the uterus, or the products of conception and endometritis.
8. Incontinence of urine dependent upon relaxation of the vesical sphincter.
9. Hematocele.
10. Floating kidney.
11. Prolapsus recti.

With the last three conditions I have had no experience, yet from personal statements received from Brandt and Nissen, and regarding No. 9 from Prof. Schauta, I have no reason to doubt the efficacy of the treatment.

Hemorrhages or catarrhal discharges due to a diseased endometrium, although beneficially treated by Brandt with his method, I have not attempted to treat with massage, because

I am satisfied that a much quicker and more radical therapeutic agent is in our hands by the use of the curette and the intra-uterine application of carbolic acid, tincture of iodine, chloride of zinc, etc.; after that massage may be used if necessary.

CONTRA-INDICATIONS.

1. All acute inflammatory processes except some which may arise during treatment.

2. Dilated tubes, except, according to Brandt's and Nissen's personal statements to me, if the uterine opening of the tube is pervious.

3. All conditions where suppuration is suspected, except as noted above.

In the employment of massage, it is of importance to know which form is suitable for the particular case, whether we need the movement *small circling*, *large circling;* these employed with *light, medium, or heavy pressure, a vibrating stroke, vibrating pressure, kneading, grinding* (malning), *and when to use stretching in conjunction, how much stretching and its direction.* The same may be said of the general and special gymnastic exercises; great care in the selection of *everything* appertaining to the treatment must be used.

It is of importance not to cause the patient too much pain; to prevent this it is necessary to watch the countenance, where sensations of excessive pain are at once observed; but, besides, the hand resting on the physician's thigh will also often make it manifest by pressing more or less according to the intensity of the pain experienced. The rule is that all treatment must be begun with gentle pressure, which can be more or less rapidly increased to the desired force; the moment it is seen that too much pain is produced, the power brought to bear on the part treated must be decreased. If an undue amount of force is used in the beginning, the abdominal parietes will at once become hardened by contraction of the muscles, which it is impossible to overcome with a continuance of such pressure; besides, the patient will be frightened and nervous. It is not at all unusual that one must use one or more "sham treatments" in the beginning, in cases of displacements when the "lifting" is to be used, and in those with tense abdominal walls, especially if they are of a nervous temperament. I have not attempted to treat patients with *very fat* abdominal walls with this

method, considering that very little or no benefit can be derived in such.

Another noteworthy point is, should one be so unfortunate as to cause a more acute inflammation or a hematoma, which is no fault of the method but rather of the physician, the treatment should not be stopped until the condition has disappeared, but its continuance should be insisted on, with this difference: it should be used two or three times daily, short séances with very light massage and the use of Priesnitz applications or ice bags during the intervals. The patient must remain in bed until again in fit condition to resume ambulatory treatment. I have seen very gratifying results in some such cases; whereas with the expectant plan considerable time will elapse.

Should ambulatory patients complain of much pain after the treatment, a cold application for a few hours will give relief.

Each séance, no matter how powerful massage has been used, must be closed with light massage, and finally placing the open hand on the lower part of the abdomen for a few moments, with vibratory pressure; the latter is also productive of a soothing influence.

Never begin massage directly at the diseased part, but keep to its surroundings until the sensibility becomes lessened, and then gradually advance with the circle movements until the desired part is reached.

From the above general statements it will be noticed that no limited duration of treatment can be given. I have given séances varying from three minutes to three-quarters of an hour, and have yet to see the first patient object to the length of the séance, having devoted from four to five hours daily, during the past six months, to the practical investigation of the method.

For diagnostic purposes alone, Thure Brandt's method stands par excellence, anesthesia excepted. This all who know how to use it properly acknowledge. Von Engelhardt, of Hamburg, told me that he could with it diagnose pathological conditions with almost absolute certainty, which, previous to his work with Nissen, was impossible without the use of chloroform.

There can be no question as to its absolute safety in proper hands. To prove this it is only necessary to mention that Brandt has treated *thousands of cases without a single serious accident.* It must not be supposed, however, that the treatment is pain-

less: there is invariably a more or less painful sensation connected with it; but the observing eye and experienced hand of the physician must be on the alert so that it is not excessive. It is, in fact, a requirement to produce some pain for a well-understood reason, but in the employment of massage and stretching we must bear in mind the standing rule, "*rather do too little than too much at one time.*"

When beginning massage of an old exudation, the small circles with light pressure are made rapidly in the direction of the lymphatics of the part treated, *supporting* it with finger in the vagina or rectum, whichever makes the best support. Sometimes both cavities are entered, the thumb in the vagina and the index finger in the rectum; this will be called for where there are large exudations. Principally the two distal joints of the first two or three fingers are brought to bear externally. After circling a few minutes in the manner indicated, the pressure is increased, and instead of making the small circles, larger circling, rubbing strokes are introduced; should the patient be able to bear a quiver squeeze (produced by the same means as the trembling stroke), these are used more or less extensively around the periphery, gradually nearing the centre. The arm is kept stiff, and the force comes from the whole upper extremity. The "heavy" treatment varies in duration from ten to twenty minutes, closing the séance with the light treatment as previously noted. The trembling stroke is also used in this forcible treatment, made by causing the fingers which glide over the mass to vibrate through contraction of the muscles of the arm. To cause still more rapid absorption of large and firm chronic exudations, the grinding (malning) movement may be practised, which is made by introducing the tip of the index finger into the anal opening, stretching the sphincter gradually in an anterior direction, and while stretching carry the finger high up into the rectum, holding the dorsal surface of the hand anterior; now use the slow pressing or grinding strokes on the exudation in the direction of the pelvic vessels. The same discretion must be used in these movements as in the others mentioned, on account of the nerve supply, which when pressed too forcibly causes intense pain. The external hand follows the direction of the lymphatics with an even, gliding stroke. The process of kneading also renders excellent service in such cases, and is made with the ball of the hand.

Variations must always be made according to the case and the temperament of the patient, and the factors laid down in the general principles are to be borne in mind; if this is adhered to we have in the above also the treatment of the less chronic and the acute exacerbations which may perchance arise during treatment. Never forget that the intra-vaginal finger is for no other purpose than that of *support* of the part to be treated; and when changing the point of support, do not move the proximal end of the finger, so as to avoid irritation of the introitus.

After finishing the massage, such gymnastic movements are made as have a tendency to diminish the flow of blood to the pelvis; the first, a very important one in the list, and which the physician himself gives, is the closing or bringing together of the flexed extremities with raised pelvis, viz.: The patient, remaining in the position occupied during treatment, and with the heels approximated, raises the pelvis; the points of support are taken from the feet and shoulders; now she separates the knees as wide as possible, and the physician, placing his hands on the external surface, forces them together slowly and evenly, avoiding jerky movements, while she resists; she then separates them again in the same manner, whilst he resists. This is done four or five times successively. This movement, which exercises the abductors of the thigh, must not be confounded with the one to be mentioned later on, as used in posterior displacements, procidentia, etc.

As soon as the exudation has subsided sufficiently, stretching of the adhesions which fix the uterus is commenced; this is done in a moderate degree in the beginning, until we know exactly how much the patient can bear without injury, and it is pursued from various points and in various positions of the patient—from the rectum, the vagina, or both, and through the abdominal walls. She may be standing, or lie in the regular position or in the knee-chest position. Generally, however, for adhesions which are situated low, it is best for the patient to stand, leaning with one arm (the right) for support on the shoulders of the operator, who sits on a chair in front and a little to the side of the patient; the hand and arm not in use for stretching is placed around her hips, which steadies him and also prevents her from retreating. The finger being introduced into the vagina, the cervix is pushed toward the

side opposite the adhesions; it may be necessary to push forward or upward. Or, again, the stretchings are done with the index finger in the rectum and the thumb in the vagina. I sometimes find it beneficial to rest the elbow on my knee, which prevents the arm tiring so soon in cases of dense adhesions, when stretchings are made through the vagina or rectum. This procedure answers admirably, in some cases of retroflexion with adhesions, to push the fundus up; the knee-chest position can also be used for the latter cases; usually, however, they are best treated in the supine position—the finger in the vagina pushes the cervix *toward* the adherent side, while with the finger tips of the external hand the uterus is grasped in the most convenient way, and drawn either steadily or with a slight vibratory motion in the opposite direction. However, which is the proper plan of treatment can only be decided upon at the time. After stretching, massage must always be used.

Ovaries which are displaced by bands of adhesions are treated on the same general principles. Introducing the finger into the rectum or vagina, as the case may be, in order to get the internal finger to the *adherent surface* of the gland, the finger tips of the external hand describe rapid small circles to the *adhesions*, thus endeavoring to free the ovary; this being accomplished, the adhesions are gently stretched, carrying the ovary toward its normal position, at the same time using massage to the adhesions.

When using massage for oöphoritis and peri-oöphoritis, the gland itself is treated with the small, rapid circle movements with very light pressure, more force being brought to bear on the surroundings; that the small cysts frequently present on the surface of the ovary are never or seldom ruptured I am sure of, yet should it occur there is no danger. With regard to inflammations of the tubes, I have not come to any favorable conclusions as to the efficacy of the treatment, with occasional exceptions. Whenever the tube is dilated, and we have made sure that the uterine opening is not occluded, the treatment as Brandt directs may be tried; but Brandt himself has occasionally in cases of pyo-salpinx gotten a drop of pus into the peritoneal cavity, evinced by severe pain on the respective side.

Begin near the uterine extremity, and always in a direction toward the uterus. Small circle and short stroking manipulations will be found to answer best. I would caution against

treating a patient with distended tubes, especially if they contain pus, if the walls of the abdomen are not sufficiently thin and flaccid to allow a very exact manipulation. It should never be done by any one who is not ready to do an abdominal section on short notice. Although Brandt and Nissen never had a serious mishap, others may not be so fortunate as these truly great masters in the manual gynecological treatment.

My personal experience in treating tubal disease is that the patients will improve temporarily, but in the course of a few weeks they will be as ill as prior to the treatment, and even during the treatment such exacerbations are apt to occur.

Massage to the uterus is usually employed with the organ in the anterior position, except, of course, in posterior fixation, if the holding bands are not sufficiently yielding to allow anteversion. The intra-vaginal finger supports the organ *always in front of the cervix*, and with the external finger massage, according to requirement, is made. When the uterus is fixed posteriorly, the supporting finger is introduced into the rectum and the massage is used on the anterior surface; at the same time we should endeavor to get the finger tips of our external hand to its posterior surface, whilst the supporting finger pushes it upward, so that stretching of the adhesions can be made. If cystitis is present, or an unusual irritability of the bladder, from whatever cause it may be, the median line of the uterus must be avoided when manipulating posteriorly, and we should manipulate more laterally to prevent increase of irritability; or the uterus may be retroverted to use the massage anteriorly. Discretion must be used in this, for, as Brandt says, we may produce the retroversion as a pathological condition by this procedure. The vesical trouble is, however, always separately treated.

The amount of weight we bring to bear when massaging the uterus will depend upon the condition of the organ. If large and flabby, we use very light circulatory massage of short duration; but the nearer it approaches the normal condition, the more pressure we can use and the longer may be our séance. The parametria should always be treated in conjunction.

In accompanying endometritis, I prefer to use the curette, etc., before commencing massage. Brandt considers light massage of the fundus useful in atrophy of the uterus. It seems to me that its usefulness will depend on the cause of the

or if the atrophy be secondary to changes in the ovaries or serious organic disease, the treatment can be of no avail. I cannot conceive its usefulness in other varieties, etiologically speaking, than in that form accompanying or following lactation, in which, as well as in the other varieties, the organ is usually retroverted, and not infrequently the wearing of a suitable pessary in such cases soon brings about a normal condition.

Massage may be used with great advantage during menstruation; it must, however, be employed very gently then, and with even greater care. The credit of showing its superior benefit at this time is due to Dr. Oscar Nissen.

Displacements.—The best manner of reducing a posterior displacement will depend entirely on the *condition* and *exact position* of the organ. Although the use of an *aseptic* sound by any one thoroughly accustomed to the instrument may not be dangerous, *it need never be used*, and Brandt, as well as many eminent gynecologists, have discarded it entirely for this purpose. *I have never seen a non-adherent uterus which I could not antevert manually*, though I commit myself to its use usually in women with very rigid, sensitive, or adipose abdominal walls, in order to save time and annoyance. Brandt describes six methods of reduction in his "Gymnastiken," but every one thoroughly acquainted with gynecological work will readily recognize in which way a particular case can be best managed.

Displacements never give rise to any symptoms except mechanical, unless there are other pathological conditions associated with them. I have come to this conclusion by the observation of a very large number of cases, and find that my experience is corroborated by the treatment which Nissen pursues: he, of late years, never endeavors to correct any posterior displacement, only treating the accompanying lesions by massage, and, according to him, invariably frees his patients of the symptoms of which they complain. How long they remain in good condition I cannot say; he claims the cure permanent. With this any one who follows such cases for a long time cannot agree, for usually it is the malposition of the uterus which causes the other lesions, and for that reason it should always be treated.

The presence of adhesions is a contra-indication to the treat-

ment of displacements by the lifting movement, after replacing the uterus in a normal position, and the neck re-massage having been used, the physician remains in the usual position, and places his index finger on the anterior surface of the cervix; at the same time the cervix may with advantage be pushed upward and backward, which will bring the fundus higher up and nearer the anterior abdominal walls, enabling the assistant to get a better hold of the uterus; then he places his free hand on the hypogastrium from above downward, pushing the integument to the lower part of this region, which shows the assistant (who should, if possible, be a trained female gymnast) exactly where the uterus is, and prevents pain to a certain extent, when the lifting is done, by taking the tension off the skin. The assistant stands with the right foot on the ground to the left side of the patient, and with the left extremity kneels on the lounge, bracing the hips lightly against the patient's knees. Now the two hands, which are held supinated, and the arms straight and stiff, are, between the thighs of the patient, placed flat on the abdomen, the position being that the thumbs are near the anterior superior spine of the ilium, and the ulnar sides nearly approximating each other; the hands are now gradually and evenly pushed into the true pelvis between the symphysis and uterus, carrying with them more superficial integument from above to prevent strain when heaving the uterus upward. The physician removes his guiding hand when the assistant's are in proper position, and as the latter gradually pushes her hands into the pelvis the body is slowly inclined forward, so that the thorax and head nearly come in contact with the patient's. A part of the uterus with the parametria are now under the fingers of the assistant, which are now slightly bent so that the organ can be more readily carried upward; this is done by following the direction of the sacral curvature with a heaving movement combined with slight vibration. When the assistant lifts the uterus, the physician will feel the cervix gradually glide away from his supporting finger; and when a stretching of the vagina at the cervical junction is appreciated, the assistant is notified to cease the lifting, and holds the uterus in the attained position for a few seconds, when the physician orders a forward movement, upon which the assistant loosens the grasp gently with the slight forward movement, done with the fingers, which throws the uterus,

provided everything has been properly done, into anteversion. When the assistant loosens his hold on the organ, the physician must receive it on the finger again the same as it was previous to the gymnastic movement. The lifting is done three times, after which follow the regular massage and the exercises for strengthening the floor of the pelvis. The latter is done by the patient raising her pelvis—in the same manner directed for the movements after massage for exudations, etc.—to diminish the flow of blood to the pelvic organs; but instead of the hands being placed on the external surface of the knees, they are placed on the *internal* surface, and the physician separates them as wide as possible, with resistance on the part of the patient; this done, she closes them again, and the resistance is reversed. This exercises the adductors of the thighs, and, combined with the raising of the pelvis, prevents an undue flow of blood to it. When these movements are finished she rises from the lounge, without decided exertion, in which the physician aids her by placing his hand to her back between the shoulders; then he inserts his thumb into the vagina on the anterior surface of the cervix at the vaginal junction, and presses backward and upward for a few seconds, to relax anteriorly and to cause contraction of the fixating parts posterior. After this she stands firmly braced against some unyielding object, as a wall or desk, with the hands and feet turned inward, leaning slightly forward, and a rapid percussion of the loins and sacrum is made. Beginning in the lumbar region, the parts are percussed down on either side to the buttocks with closed hand, but the wrist is held loose, so that the raps have a sort of spring, and they are given with very little force. Their intention is to vitalize the pelvis through the nerve supply. After percussion the open hand is stroked over the parts three or four times from above downward for its soothing effect. If amenorrhea is present, the percussion is done with more force and the brace of the patient is not so firm. After this she is required to lie on a couch on her abdomen for about fifteen minutes before she receives the remaining gymnastic exercises intended for her.

The liftings as described are used with some modifications for all other forms of displacements (anteflexions excepted), also for recto- and cystocele.

In procidentia, for instance, the uterus is carried much

higher, sometimes nearly to a level with the umbilicus. If it is a lateral deviation, the hand is first introduced on that side to which the uterus is inclined, and during the lifting that hand pushes the organ slightly in the opposite direction.

All liftings are made first upward, then forward in the axis of the pelvis.

A word in regard to the total extirpation of the uterus in cases of complete procidentia—an operation which has been done a number of times in this country and in Europe, if the organ could not be retained by ordinary means. I want to be put down as considering it an *unjustifiable operation in every instance* until the method described has been given *a fair trial in experienced hands;* and if it does not succeed, *then fixation of the organ to the anterior abdominal walls, or the shortening of the round ligaments, should be used* before resorting to the total extirpation, especially in women who have *not* passed the menopause.

Cystocele.—After the "heaving" of the uterus a vibratory pressure is applied to the inferior branch of the pudic nerve, beginning at the perineum and passing forward on the external side of the labia majora; next the protruding part is stroked upward and inward with the tip of the index finger, using firm vibratory pressure, care being taken to avoid the urethra; this is done several times on either side of the latter canal.

Rectocele.—After lumbar and sacral percussion, which should be used before the liftings for any condition, to be repeated, however, after they have been made, the heaving of the sigmoid flexure is done, as follows: The patient being in the usual position on the lounge, the physician stands on her right side, placing his left hand on her right shoulder. The extended right hand is placed to the inner side of the left iliac crest, and is pushed inward and downward deep into the pelvis with a vibratory motion; now the two distal phalanges are slightly curved, and the pelvic contents with the abdominal coverings are pulled in an upward direction as far as possible, with a vibration. The same movement is used in prolapsus recti.

Next follow lifting of the uterus and vibratory pressure on the hypogastric plexus. Brandt uses the latter in conjunction with pudic pressure after uterine liftings for other purposes. He also requires his patients to use a vaginal douche, night and morning, of about half a pint of *cool* water.

The displacement least amenable to treatment is anteflexion, particularly if congenital, although the latter rarely gives rise to trouble. Yet my results have been fully as good with Brandt's method as any other mode of treatment. The success depends on the condition of the cervix at the point of flexion, just as it does in posterior deviations. If the muscular structure at the flexure is not too much atrophied, there is hope of effecting a cure; but cases where the point of flexion is stiff and cartilaginous, and little or no muscular structure left, as we not infrequently find it in congenital flexions, cannot be cured by any form of treatment. The treatment is to introduce the finger anterior to the cervix first, and use massage on the posterior surface of the flexed point, also light massage on the body; next the internal finger is placed behind the flexion angle, either *per vaginam* or *rectum*, whichever is most suitable in the respective case, pressing the part well forward, when the external hand can usually without great difficulty retrovert the body by pushing the fingers behind the symphysis and under the corpus, gradually raising it up, and finally throwing it into a posterior displacement; now the massage is used anteriorly with very light pressure at the point of flexion. Sometimes I have succeeded more readily in retroverting the uterus in extreme anteflexion by the introduction of the index finger of one hand into the rectum, pressing the flexion angle forward, and with the finger of the other hand into the vagina push the body upward as high as possible so that the organ is almost straightened, in which position it can be held for a moment with the rectal finger, so that now the body can be retroverted without difficulty with the free hand. I have been able to cure one patient with the method described, who had, on account of the existing intense dysmenorrhea, been under treatment a number of years in intervals varying from four to six months.

A most gratifying result is obtained by Brandt's method in some cases of incontinence of urine, when dependent on relaxation of the vesical sphincter. With his permission I will briefly cite the most interesting case of the kind observed by me:

The lady, a resident of Berlin (Germany), had been under treatment of some of the most eminent gynecologists. Varied treatment, dilatation of the urethra, electricity, etc., had been used without success, and she had already resolved to undergo a proposed operation to relieve her, when an Austrian gynecologist

with whom the family became acquainted on a pleasure tour, and to whom her trouble had been confided, requested her to see Brandt on their return trip. The patient arrived there with her husband and the medical gentleman on August 10th, and with her permission, which was given through the interceding of my Austrian colleague and her husband, I was permitted to examine her and elicit the following history. Of course I also watched the treatment and followed the case to the end. Æt. 32 years; married nine years; had one child eight years ago, normal labor; no miscarriage; menstruation began at 14 years; complains of hypogastric pain and a bearing-down sensation; lumbar pains; no pain in the inguinal regions; cold hands and feet; headaches. The pains are variable as to time and severity, and are entirely independent of the menstrual flow, which is regular every four weeks, painless, normal in quantity and quality, lasting two days. Slight thick leucorrhea; bowels regular. The urine voided on rising in the morning is normal in every respect. For the past six years she has been *utterly unable to retain urine the moment she was on her feet;* the trouble came on gradually after birth of the child.

The uterus is in normal position; freely mobile; slight laceration of the cervix and some hyperplasia of the organ; the right ovary is sensitive (slight oöphoritis), the left normal; tubes normal; the ureters are palpable and apparently healthy. Treatment was commenced on the same day.

On August 14th she feels better and is able to retain her urine for two hours.

August 16th, uterus not so hard and ovary not so sensitive; she retains urine from 8 A.M. to 2 P.M.

August 18th, she receives the last treatment, and, feeling herself perfectly well, is discharged a well woman.

The treatment, besides some gymnastic movements, consists in percussion of the lumbar and sacral regions in the manner already described; then the alternating bladder-shaking is done, as follows: The patient lies on her back in a semi-prone position, with the thighs and legs flexed as for examination; the operator holds his fingers and hands stiff as for uterine lifting, and places them in the hypogastrium by the sides of the bladder, and makes alternately with each hand a slight vibration in an upward direction, as though intending to lift the viscus upward and forward. Following this, such other gymnastic movements are given as may be indicated; then the local treatment of the uterus, if such is necessary. This done, we use the perhaps principal treatment for the vesical trouble. The left index finger is introduced obliquely, slightly bent to surround the neck of the bladder; the other three fingers are

closed upon the thumb, which is turned into the hand, and the free hand is placed around the wrist of the employed hand to better regulate the pressure to be used; now the finger is caused by all the forces combined to make a vibration against the neck of the bladder, pressing moderately against the symphysis; this is repeated three or four times, and then with the right index finger the opposite side of the neck is treated likewise. Exercises of the adductors (and also of the abductors, if required) of the thigh are given, to be followed again by percussion of the lumbar and sacral regions, etc.

I, too, have had several brilliant results in such cases. One may serve as an example in which this treatment alone was used. The patient, æt. 58 years, had incontinence two years; after the fourth treatment she could retain her urine over an hour, and in less than four weeks was entirely cured. Two children, 9 years old, suffering with the malady, were cured by me in three weeks, and the first four and five séances respectively were devoted to gymnastic exercises alone.

In children and virgins, however, we use the index finger against the neck of the bladder *per rectum* instead of *per vaginam*. In cases of contraction of the bladder, which results in some cases of complete incontinence, I add dilatation of the viscus with water, as practised by Nissen, of Christiania. For this I use Kuestner's bladder-irrigating apparatus—which can be secured of J. Reynders & Co., of this city—and fill the bladder to its utmost extent. When the patient complains of much pain, the inward flow is stopped, and after the lapse of a few minutes a little more water is allowed to enter. This treatment is also used daily. Dr. H. Marion Sims recently read a paper before the New York Obstetrical Society in which he advocated this form of treatment (dilatation of the bladder with water for incontinence) without the knowledge that it had been used previously by others. Sims uses a Davidson syringe to fill the bladder, and I can indorse the superiority of this over the glass irrigating bottle from subsequent experience.

My personal experience with the manual treatment is that cases of posterior displacement of long standing are exceedingly difficult to cure, especially if sharp flexion angles are present. I have been unable to satisfactorily cure a case of the latter variety, although the attempt has only been made with three such patients. I also prefer the introduction of a suitable

pessary after the treatment, if the body of the uterus does not tip over the upper bar, because the manual replacement causes more or less pain in most cases. If there is a flexion which cannot be benefited by the manual treatment in a few weeks, and in which a pessary is useless and the symptoms return (for they always disappear by this treatment properly used, even though it be temporary), I should do the Adams-Alexander operation rather than waste months of time and be perhaps disappointed in the end. By benefited I mean, for instance, if a patient cannot wear a pessary and we use the manual treatment alone, if the uterus then after a number of séances is found to remain in normal position, even though only occasionally, we should not be discouraged, for eventually we are apt to be rewarded by a complete cure.

With *cystocele* and *rectocele*, if no improvement takes place in four weeks it is useless to continue. One patient was treated eight weeks daily by myself and my assistant without benefit. In such cases operative measures should be used. I have succeeded, though, in curing one patient 60 years old in a few weeks, who had prolapse of the anterior vaginal wall, the protrusion outside of the labia larger than a hen's egg and of two years' standing. After the lapse of three months there has been no return of her trouble. It is also very difficult to eradicate the vaginal prolapse accompanying procidentia.

Procidentiæ, however, provided the muscular structures holding the uterus are not too much atrophied, yield a most happy result. Three such cases are on my record. One especially worth mentioning was a young woman with *complete procidentia*, retroflexed uterus, prolapse of the anterior vaginal wall, and *a laceration of the perineum extending to the sphincter ani*. She was cured in every respect regarding the displacements and the accompanying symptoms, despite the perineal tear. This case and the previous one mentioned were shown to several of my colleagues in the German Poliklinik, before treatment began and after a cure had been established. Another equally remarkable case was one which I treated in Christiania under Nissen's supervision. The patient, a peasant, was 65 years old, in poor health (chronic rheumatism). She had had two children, and a partial prolapse ensued after the birth of her first child. Complete prolapsus occurred after the birth of the second child twenty-three years ago. Dr. Nissen

had not attempted to reduce the dislocated uterus, which was in condition of senile atrophy, on account of her general poor health and the inability of the patient to abstain from physical exercise, but satisfied himself with treating the extensive erosions which were present with local applications. He kindly permitted me, however, to treat the case. After the first treatment the womb did not again protrude from the vulva, and after the fourth it remained in normal position and the erosions rapidly disappeared *without* further local treatment. This patient resided outside the suburbs of the city, so that she had over an hour's walk to come to Nissen's office. His nephew, Dr. Christian Nissen, recently informed me on inquiry that the cure was permanent, she receiving treatment for only a few weeks after my departure.

How the method brings about a cure in displacements, especially of procidentia, has been studied by me since the time of my acquaintance with it, both on the living subject and the cadaver, and I have come to the conclusion that we must look to various factors for the reason. B. S. Schultze, I was told, considers the only cause to be the contraction of the sacro-uterine ligaments; and if we open the abdomen in a cadaver and pull the uterus forcibly down with vulsellum forceps, we find that the most appreciable strain is on these ligaments, but at the same time *all* of the attachments are put to some tension, and it therefore seems to me that the strengthening of all the muscular tissue in connection with the uterus acts as a factor in bringing about the desired result. That the exercises of the adductors are an important factor in hastening the cure there is no doubt in my mind. Von Preuschen in his articles endeavors to prove that it is the sole factor, yet cures by Brandt and Nissen have been produced previous to the introduction of these exercises; at the same time I grant the correctness of Von Preuschen's observations as to the effect of these movements on the pelvic floor.

I hardly need say that the result in the treatment of pelvic exudations is excellent in the majority of cases. The benefit of a somewhat similar treatment has been recognized by many others, and is frequently put into practice both here and abroad.

To close, I will add one case of salpingo-oöphoritis. The patient had a pathological anteversion; the right ovary was

attached by adhesions to the brim of the pelvis backward, enlarged and very sensitive; the tube was also enlarged and tender. The left tube and ovary were in the same condition, with the exception that the gland was not so far back. She had been a constant sufferer for six years, and two prominent colleagues had proposed the removal of the tubes and ovaries. She was treated daily for two months, the séances varying from half to three quarters of an hour, with the result of a complete cure, and none of the old symptoms have so far returned; but, as yet, only three months have elapsed. Still my experience has been that relapses of symptoms return in from two to eight weeks, if they return at all. A fresh exciting cause, however, may produce a recurrence at any time.

It is to be sincerely hoped that the profession will give the subject the attention of which it is worthy, so that by accumulated experience we may arrive at definite conclusions with regard to the indications and contra-indications.