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ORIGINAL COMMUNICATIONS.

TWO YEARS' EXPERIENCE WITH PELVIC MASSAGE IN GYNECOLOGICAL CASES, WITH REPORTS OF CASES.[1]

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(With twenty-nine illustrations.)

I HAVE chosen the term "pelvic massage" advisedly, for I do not think it just to characterize a procedure as "Thure Brandt's" unless his method is practised in its entirety. My reasons for discarding the various Swedish movements which Brandt employs in conjunction with massage of the pelvic organs I have stated in a paper published in the New York *Medical Journal*, January 24th, 1891, shortly after my return from Sweden. The reasons then given—that they take up too much time and necessitate the aid of a trained assistant—still hold good with equal force. Besides, the experience I have gained since my visit to Thure Brandt has provided me with a more

[1] Read before the Section on Obstetrics and Gynecology of the Academy of Medicine, November 25th, 1892.

valid reason than expediency. My results without the aid of the Swedish movements have been good and will compare favorably with those I observed in Stockholm under Brandt himself. Of course by this I would not wish for a moment to be understood as considering myself his equal either in manual dexterity, expertness, or ability as a diagnostician, for in these three qualities, although only a layman, he has few equals. But the point I wish to make is that I have been able to afford relief, and in many cases effect a cure, by a combination of massage and stretching, without resorting to the various muscular exercises, active and passive, which Brandt employs. It was not long after my return from Sweden that I gave up "uterus lifting" also, as practised by Brandt. Though a valuable procedure, I discarded it because it was uncouth, had the appearance of harshness, was not easily borne by the patient, was a difficult maneuvre to carry out, and required a skilled assistant. As a substitute I have carried out lifting or elevating the uterus with the fingers in the vagina, keeping the fundus forward at the same time with the hand over the abdomen. In this way I have been able to elevate the uterus so that the fundus would reach midway between the pubes and umbilicus. Dührssen [12] states that he can elevate the fundus to the umbilicus with the two fingers in the vagina. As he does not possess fingers of unusual length, I fail to understand how he accomplishes it. Pawlik [14] devised a drum-shaped instrument with which to push the fundus forward and upward; and Sileski [15] employs a sound with a shoulder, which he introduces within the uterus. The latter course is reprehensible, for it is not free from danger and is at total variance with the principles of pelvic massage.

In practising the method I have not failed to call in the aid of any auxiliary measure which I thought might hasten the object in view—the cure of the patient. Consequently, after a *séance*, I frequently placed a medicated tampon behind the uterus; and in other cases, after I once got the uterus forward, I tried to keep it there until the next *séance* by well-placed tampons. I resorted to the latter procedure especially in those cases in which redressing the uterus gave considerable pain and was attended with some difficulty. If the objection be raised that these auxiliary measures vitiate the results which I claim for pelvic massage, my answer is, if any one will read the histories of the cases embodied in this paper he will learn that most of

[12] Bibliography will be inserted at end of paper.

them had been treated for years with medicated tampons in the vagina without improving the local condition or relieving the woman of her symptoms. For the purpose of comparison I treated a number of cases without following up the treatment by tampons, and could note no appreciable difference in the progress of the cases from those cases in which tampons were used. The only benefit I could observe from the latter course was that in some cases the woman was spared the unavoidable pain connected at times with anteverting the uterus.

It is a matter of surprise to me that the method under question has not made further headway in this country. In Germany it has, within the past six years, gained a firm and extensive footing, and the literature on the subject has grown to considerable dimensions, as a glance at the bibliography (which makes no pretension to completeness) appended to this paper will show. Seldom has a method met with so few dissenting voices as this one has in Germany. The few who at first raised objections on theoretical grounds are now themselves resorting to it. Thus we find Olshausen, who condemned it a few years ago from *a priori* reasoning, confess to a change of front a few months ago. In a discussion at the Berlin Gynecological Society, following the reading of Dührssen's paper, Olshausen[17] said he agreed in the main with Dührssen and that he had great faith in massage when applied to the proper cases, such as para- and perimetritic adhesions and fixations of the uterus. He detailed the history of a case of pelvic exudation of from eight to nine years' date, where the uterus was adherent by a broad, firm band to the right sacro-iliac articulation. In about twenty *séances* the uterus was rendered movable, so that it could be brought almost to the normal position. The case was complicated with a left pyosalpinx, but, as he had observed that it frequently discharged through the uterus, he did not hesitate to employ massage. After each *séance* the woman noted a flow of thin, purulent fluid upon her chemise.

The method is practised extensively in Austria and in Russia. Even in France it has excited such interest that the Government recently sent a commissioner to Stockholm to investigate what there was in it. The commissioner—M. Stapfer [18]—studied for some months with Brandt, and on his return published a most glowing account, advising its immediate introduction into France. He could not, however, refrain from giving a side

blow to the Germans, saying that the method they practised, *sine* the Swedish movements, was only a bastard form, and that none but Brandt's system, without modifications, was worthy of being adopted in his country.

Why is it, then, that American gynecologists so far have accorded this method such a lukewarm reception? The time is past when the reason could be expressed in a broad grin, for no one is, or ought to be, so ignorant of the subject as to offer any objections on moral grounds. Surely every one who keeps abreast with current literature knows before this that the various movements included under the term "pelvic massage" are carried out through the abdominal walls, and are as little likely to excite the woman's sexual desires as is abdominal massage for constipation. The finger or fingers (if two are used) in the vagina merely steady the part to be massaged, and the only movements they are intended to execute are those which loosen or stretch the adhesions and draw the uterus forward and upward. Every respectable person will take care, as he would in an ordinary vaginal examination, to press the vaginal finger against the posterior wall and keep the remainder of his hand from coming in contact with the pubes. Whether a procedure be decent or indecent depends often more on the physician than on the features which enter into it. A mere physical examination of the lungs in a female patient can be made more erotic than a sitting of pelvic massage of an hour's duration. I have applied the method probably to over a hundred different women, and in no instance did I observe any sexual excitement, though I have been keeping a watchful eye for it. Further still, if it be applied only in those cases in which it is indicated, the feelings of the patient during the treatment will be anything but pleasurable, for it cannot be denied that it is attended in most cases with more or less pain. But I have met with only one patient thus far who discontinued the treatment on account of the pain accompanying it. The patient was a hysterical, hypersensitive spinster with a retroversion and general perimetritis, and who screamed out loudly when the abdomen was touched, no matter how lightly. Of course I would not be understood that it is necessary to give much pain in the application of the treatment. The production of pain must be avoided as much as possible, for obvious reasons. The amount of pain we cause must frequently be our guide as to the degree

of force we may use within safe limits. But in stretching adhesions, and in loosening fixed uteri, tubes, and ovaries, a *modicum* of pain is often unavoidable.

In what affections of the pelvic organs is massage indicated? Brandt employs it in all pelvic diseases excepting in fibroid, cystic, and malignant growths and in pus accumulations. Combined with the Swedish movements, I have seen Brandt obtain good results in menorrhagia, metrorrhagia, amenorrhea, and dysmenorrhea. But these are symptoms only, and often due to conditions which we can remedy with the means hitherto at our command.

My course has been to call it into service chiefly in those obstinate affections which resist the ordinary treatment in vogue, and for the relief of which serious operations have been undertaken with results that are far from gratifying. I have reference to the residua of inflammatory processes, found in the form of cicatricial contractions, thickening and shortening of the several uterine ligaments, wide, loose adhesions cementing together the peritoneal surfaces, firm, stout cords and bands passing from organ to organ or from organ to pelvic wall, displacements and fixations of the uterus, tubes, and ovaries. When I had any reason to suspect the presence of pus, whether in a tube, ovary, or cellular tissue, I withheld my hand from treating the case with this method. But every thickened or enlarged tube and every swollen ovary were not looked upon, as they are by some, as being filled with pus, crying out, *Noli me tangere!* It is about time that we came to an understanding as to what is meant by pyosalpinx. The tubes one frequently sees removed, and which contain a few drops of muco-purulent fluid, do not deserve the dignity of the title of pyosalpinx. They do not deserve this from either a pathological or clinical standpoint. I have treated several women (Cases II., V., XI., XV.) with such tubes and they have got well, and some of them (Case V., and others not reported) gave birth afterward to healthy children. Nevertheless I wish to state emphatically that when there is an unmistakable collection of pus in the pelvis, or an acute or subacute inflammatory process going on, pelvic massage is undoubtedly contra-indicated. While I admit it is not always easy even for the most skilful diagnostician to tell whether pus be present or not, errors in diagnosis need not be frequent if one be versed in pelvic palpation and in the

symptoms of pelvic suppuration. None other has any right to engage in this form of treatment, and this is a statement which I desire to emphasize most strongly. I feel it necessary to do this because I often meet with practitioners who, laying no claim to special knowledge in pelvic affections, tell me they are in the habit of employing the method. Here it may be opportune to state that to me it is unintelligible how it can be rightly applied without a properly constructed couch and without having learned it practically. I can only repeat what I have said on a former occasion, and what every one else has said who has written on the subject from practical knowledge: that it is not to be learned from books or articles, nor is it to be acquired in a few days. After a stay of some weeks with Brandt and practising under his supervision, I began to apply the treatment, on my return to this city, with the greatest caution and with the feeling that I still had much to learn. I may have been overcautious, but to my care and caution I attribute the fact that, up to this time, in not a single instance have I done harm with my manipulations. This is in spite of the circumstance that I have used it in several cases where the tubes and ovaries were very much swollen and firmly adherent, and when it was not always possible to be sure at the outset whether pus were present or not. In these cases, at the beginning, I have used none but the most gentle manipulations, and it was only when I learned more about the local conditions and what they could tolerate that I applied sufficient force to stretch and break up the adhesions and replace the organs in their normal positions. The harm that may be inflicted when these precautions are ignored, and when the necessary practical, to say nothing of the special, knowledge is wanting, can be easily understood.

I was twice tempted to use the treatment tentatively in two cases of acute pelvic inflammation before all the acute symptoms had subsided, because everything that I had tried, including galvanism and faradization, left me in the lurch. In the one case it worked well; in the other it produced an exacerbation of an already existing pain, without, however, making the local condition any worse, and of course I desisted from a further use of it. In addition to the class of cases already referred to, I have made use of the method in cases of subinvolution which did not seem to make any progress with the usual modes of treatment. The results in these cases were astonishingly good

and rapid. In one woman, whom I myself delivered, owing to a large child (twelve and three-quarter pounds) and a rather tedious labor, the uterus three months after confinement had not undergone complete involution. I then treated her a whole month with intra-uterine stimulating applications, medicated vaginal tampons, hot and cold douches, ergot, strychnine, etc., and all to no purpose. Subsequently in half a dozen applications of massage the uterus was reduced to its normal size and the leucorrhea and symptoms of bearing-down and weight in the hypogastrium disappeared. In two of my cases (Cases VI. and IX.) subinvolution existed with other complications and was rapidly benefited by this treatment. When we take into consideration the effect massage has upon the uterine tissues these results are to be expected.

Lindblom[36] was the first, I think, to draw attention to the fact that when the unimpregnated uterus is *masséed* it can be felt to undergo distinct contraction and then to relax. Arendt[1] described this feature more fully in a paper before the Tenth International Medical Congress. He stated that the contractions occur as follows: The posterior wall first bulges out, then the anterior, and afterward the whole organ can be noticed to grow stouter, thicker, and more firm. This phenomenon can be observed in almost every case, but it was particularly marked in one of my cases (Case IX.). At the commencement of the manipulation the uterus could not be outlined; after a time it could be felt forming, as it were, under the hands; later the whole organ could easily be mapped out, though in a soft and flaccid condition. Continuing with the circling and vibratory movements, one could appreciate it growing firmer, harder, and smaller, and it would remain in this state until the end of the *séance*.

I have had no success with the method in complete prolapsus of the uterus—in those cases in which the uterus and vaginal walls are external and lie between the thighs. I tried it faithfully in three such cases, but only in one was there even temporary benefit. This corresponds with the experience of most other observers. I cannot very well understand how it could be otherwise. For in these cases the uterine supports are so relaxed and atrophied that no amount of manipulation will restore their tone and muscular elements. But in cases where there was only a slight descent, say to within an inch of the

vaginal orifice, I have had good results, providing the floor of the pelvis was in a fair condition. I have treated in all five such cases, and in every case, after a period of treatment lasting from four to six weeks, the uterus remained from one to two inches higher in the pelvis (see Cases VI. and XII.). With this result the symptoms of weight in the hypogastrium and bearing-down sensation disappeared. The symptom of frequent micturition was not always so amenable to treatment. In two of the cases it persisted in spite of the improved position of the uterus.

Now we come to the most important pathological lesions in which pelvic massage is especially indicated and in which I have had the most gratifying results—I mean the residua of inflammatory processes in the pelvic cavity, already spoken of. These form a very large percentage of the cases gynecologists have to treat. Bandl's[4] estimate of fifty-three per cent is below the mark for the cases met with in this city, if I may judge from my own limited experience. In the service of Drs. Emmet and Buckmaster in the Outdoor Department of the Woman's Hospital, at which I assist, the number of women suffering from these pathological lesions is fully seventy-five per cent of the total number. Some of these cases are benefited by the routine treatment of iodine, glycerin tampons, and hot douches, but by far the larger majority fail to receive any relief after months of treatment.

What are the other methods of treatment in vogue for these pathological conditions? This is an important question, for if they meet the indications and are attended with success there is little or no need of pelvic massage. First there is Schultze's method of forcibly breaking up the adhesions, the patient being deeply narcotized. It is admittedly a dangerous procedure and limited by Schultze himself to those cases uncomplicated by disease of the tubes or ovaries. This limitation narrows down the number of cases in which it is indicated to a very small percentage; for, in my experience, it is seldom that a displaced and adherent uterus is found without one or other tube or ovary being diseased and adherent. In the fifteen cases which I report in this paper, in three only was there no tubal or ovarian complication. Further, it does not always succeed in breaking up the adhesions. I reported elsewhere[5] a case of retroflexion with fixation in which Schultze had failed to free the uterus by three different attempts, while Brandt subsequently succeeded in

bringing the uterus forward in six weeks' treatment. In one of my cases (Case XIII.) the method was carried out by a careful and able specialist, but it was a failure and the woman was made much worse by it. Secondly, we have laparatomy, or, to speak more correctly, celiotomy, the object of which is to remove radically the adhesions and perimetritic bands. The methods followed by different operators vary in many important details, but the end in view is the same. One class of operators extirpate the diseased adnexa; another class, after removing the adnexa, stitch the uterus to the abdominal incision—ventro-fixation; and a third class, the more conservative, are satisfied with breaking up the adhesions, loosening the fixed uterus, tubes, and ovaries, puncturing the ovaries if they contain small cysts, resecting a portion of the tubes if they are not patent, shortening the round ligaments within and outside of the abdomen, and stitching the broad ligaments to draw the uterus forward. The insurmountable objection to celiotomy in these cases is that it itself is prone to be followed by similar pathological conditions which it is intended to remove. Its sequelæ are peritoneal and intestinal adhesions, and as yet no form of technique has succeeded in preventing them. Illustrations of this are constantly met with in literature. Numerous cases are recorded in which a second and a third operation was found necessary to remove the adhesions caused by the prior operation. A pregnant example of this class is abstracted from *Centralblatt für Gynäkologie*, No. 34, 1892, in the "Status of Gynecology Abroad" in the New York *Journal of Gynecology and Obstetrics* for the month of November, 1892: "Triple Laparatomy, with Remarks on the Significance of Peritoneal Adhesions."

"Dr. Odebrecht reports a case in which he performed laparatomy three times on the same woman. The patient was 18 years of age, single, and suffered with pelvic pain and gastric disturbances. The uterus was in sinistro-retroflexion, the left ovary enlarged, sensitive, and fixed. The right ovary was slightly enlarged, but freely movable, and not sensitive to pressure. At the first laparatomy the left ovary and tube were removed and ventro-fixation of the uterus carried out. In a few months the patient returned suffering more severely than before the operation. Laparatomy was again done and the right tube and ovary removed. The uterus was found firmly adherent, by means of a short band, to the lower part of the abdo-

minal wound. It required considerable force to break this up. No other adhesions were found. In the second week after the operation the patient began again to suffer from pain and inability to move about, and great discomfort after partaking of food. At the third laparatomy the omentum was found adherent to the cicatrix of the abdominal wound for its whole length." The subsequent history is given only during convalescence, and states that the patient suffered at first from severe pain in the abdominal wound, but in a couple of weeks this ceased and she was enabled to go about without pain.

Further illustrations are found in the relatively numerous cases one sees in private and dispensary practice which are rendered much worse by the operation. In some of these cases the vaginal vault is found tense and firm, the uterus is fixed in some malposition, and the whole lower abdomen is exquisitely tender to the touch, so that a satisfactory bimanual examination is impossible. The woman suffers from pain all over the pelvis, has no ambition, tires easily, and is generally very wretched. In a case presenting these characters that I saw recently in dispensary practice, the operation had been done by a very careful, conscientious, and skilful operator. On mentioning the case to him he expressed great surprise, as the patient had had a smooth and excellent convalescence. How many cases reported conscientiously as successful, with smooth recoveries, turn up afterward at some dispensary or in some doctor's office with just such a history as the foregoing! During the current year at the Outdoor Department of the Woman's Hospital I have seen four cases of this kind, operated upon by different surgeons, all of eminence and undoubted skill.

All this may sound like an old and oft-repeated tale, but in the burden of truth contained in it do we find the *raison d'être* of a method like pelvic massage, which, it must be conceded, is not easily learned, and which calls for difficult labor on the part of the operator.

It will be gathered from what has gone before that I do not present the method as a *panacea* for all the ills woman's generative organs are heir to. But what I *do* claim for it is that it is the ideal method for the class of cases under consideration. This claim does not assume that it will *cure* every case with lesions resulting from a prior inflammation. But in the cases that it does effect a cure it is an ideal one, in which the organs and

surrounding tissues are restored to their normal healthy state. There is no mutilation, or fixing of organs in positions which are fully as pathological as those existing prior to the surgical procedure. In my experience I have been able to effect a cure—by which I mean an *ideal* cure—in about fifty per cent. Of the fifteen cases I report in this paper, seven (46.60 per cent) were cured; six (forty per cent) were symptomatically cured, three of these with the aid of pessaries; and two (three per cent) were made no better. In these two cases is included the case that discontinued treatment before sufficient time was afforded to determine whether the method would have ultimately succeeded. Of course I recognize the fact that the data I present are insufficient to warrant any general deductions, but, as they correspond in the main with those of others who have had a larger experience, they carry considerable weight. Ziegenspieck[11] reports twenty-two cases with sixteen cures, or about seventy-three per cent. Profanter[12] published fourteen cases treated under Schultze's supervision by Brandt during his stay at Jena. Of these, ten were cured, or seventy-one per cent, and four, or twenty-nine per cent, were symptomatically cured and the local lesions almost removed. I could quote many others who have had almost equally good results.

The cases put down by me as symptomatically cured deserve further consideration. The patients were more than relieved of their symptoms. The adhesions were loosened and stretched so that the uterus and ovaries were freely movable, and, if found necessary, a pessary could be worn with comfort and without the fear of inflicting harm. This is an important desideratum, and to the lack of fully appreciating its worth must be attributed the discredit which often attaches to the use of pessaries. I have several times removed a pessary from the vagina of a woman in whom it was a criminal act to have introduced one. The uterus might have been adherent posteriorly, the ovaries swollen, tender, and fixed, one in Douglas' space and the other to the side of the pelvis far forward, and still a pessary was crowded into the vagina. Everything was put on the stretch. The ovaries were pressed against by the bars of the instrument, and with every step or movement the woman made she ran the danger of calling into existence an acute inflammatory process. But when the uterus is freed from its adhesions, and the ovaries replaced in their normal positions in the sides of the pelvis, and

all tenderness of the pelvic tissues removed, a pessary may prove a very valuable aid and may ultimately bring about a permanent cure of a uterine displacement. Gynecologists with strong surgical tendencies cannot stigmatize this aid as "tinkering," for it is one they themselves bring into requisition after surgical procedures for the cure of dislocations of the uterus.

A word about endometritis as a complication of the cases in which pelvic massage is indicated. Some (Dührssen and others) are in the habit of curetting the uterus before commencing with the treatment. My course has been the opposite. It was only when the uterine discharge was due to gonorrheal infection, and persisted after the perimetritic bands and adhesions were removed and the uterus restored to its normal mobility, that I deemed it necessary to apply a special treatment for the endometritis. By adopting this course it is remarkable in how few cases I found it necessary to resort to the special treatment. For, in the majority of cases, as soon as the local lesions were improved the discharge ceased, thus showing that apparently T. A. Emmet's teachings hold good in a fair percentage of cases. I am not now concerned with the question whether endometritis is always caused by para- and perimetritis and their sequelæ, or whether it is the cause of these affections. I merely state the result of my clinical observations, and, until pelvic pathology rests on a more certain foundation than at present, speculation on these points is unprofitable. As in most things, probably in this also, the future will prove that the truth lies midway between the two extremes.

The following cases have been selected from a large number as typical of the results I have had with pelvic massage.

Case I. *Retroflexion with firm Perimetritic Adhesions; Left Oöphoritis.* (Abstracted from *Medical Record*, July 11th, 1891.) —S. H., æt. 30, married fifteen months. Seen January 6th, 1891, at Mount Sinai Dispensary. Had pelvic pain, dyspareunia, and dysmenorrhea ever since miscarriage ten months before. Had been treated at various dispensaries for some time without any marked relief. Treated for two weeks at Mount Sinai Dispensary by pelveo-abdominal galvanism without success.

Diagnosis.—Retroflexion with firm perimetritic adhesions of fundus posteriorly and of cervix anteriorly. Left oöphoritis. After three *séances* of pelvic massage, menses set in at the usual period *and were painless.* After four more *séances* uterus was

quite movable and could readily be brought to the normal position.

CASE II. *Retroversion with Fixation; Double Oöphoritis; Right Salpingitis.* (Abstracted from *Medical Record*, July 11th, 1891.)—L. M., æt. 25, married six years, one child 5 years of age. Suffering for three years with pelvic pain, dysmenorrhea, frequent and painful micturition, headache, nervousness, and inability to do her housework.

Diagnosis.—Retroversion with fixation, double oöphoritis, right salpingitis. Came under treatment February 12th, 1891. On February 18th all pain had disappeared. March 1st, period set in without pain. Is now able to attend to her household duties. On April 11th, after a severe drenching, had a return of some of her symptoms, which disappeared after a few applications of massage. Right tube is about half the size it was when

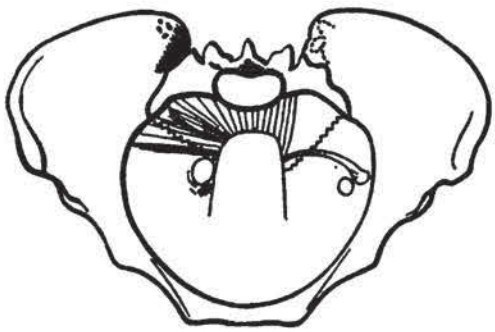

FIG. 1.

first came under treatment. Saw the patient lately; said she performed all her work and was quite comfortable; had little or no pain. Did not have an opportunity to examine her.

CASE III. *Retroversion; Adhesions posteriorly and between Cervix and Anterior Wall; Posterior Perimetritis; Fixation and Enlargement of Right Ovary.*—B. P., æt. 37 years, came under treatment January 27th, 1891. Married fourteen years; has one child 13 years old. Since birth of child has suffered with pain in the back and in both groins. Menstruation is profuse and very painful, the pain continuing during the whole period. Frequent and painful micturition; has to urinate every hour or two. General health very much run down; has had to give up her vocation of nursing, on account of her health.

Uterus is in complete retroversion; fundus is large and lies low down in Douglas' cul-de-sac; it is firmly bound by a broad band

passing to the sacrum; cervix is adherent anteriorly; utero-sacral ligaments very tense and shortened; some thickening of the right broad ligament. Right ovary, double its normal size, is adherent to the side of the uterus at the level of the internal os; left ovary normal in size and in mobility (see Fig. 1).

Patient subjected to pelvic massage every other day.

March 5th: Quite free from pain. Uterus can be brought up to beyond the promontory. Right ovary much smaller and is no longer adherent to the uterus.

April 10th: Painless menses. Patient continues to be free from pain. Uterus is quite movable and is easily anteverted; kept in anteversion in the intervals of the *séances* by ichthyol tampons. Right ovary quite movable and seems to be of normal size.

May 10th: Patient well in every respect. Uterus retains

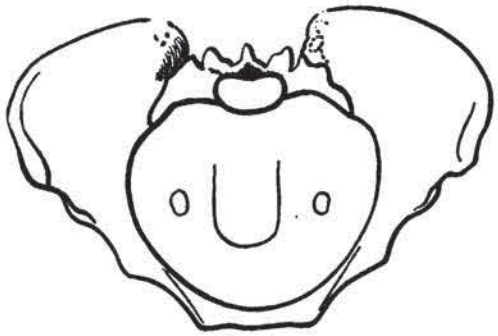

FIG. 2.

normal position without the tampons. No thickening of the right broad ligament (see Fig. 2).

CASE IV. *Restricted Mobility of Uterus; Thickening and Shortening of Utero-sacral Ligaments; Fixation of Left Ovary to Side of Pelvis.*—L. S., æt. 29, married eight years. Came under treatment February 1st, 1891. Had one child 7 years old. Had never had a miscarriage.

About four and one-half years before began to suffer with pain in the back and from a feeling, when going upstairs, as if the whole abdominal contents were coming down. Had pain in the left groin almost constantly. Her menses were regular, moderate in amount, and continued for three days, during which her backache was much more severe. She also suffered from headache and a feeling of numbness in both thighs. Her digestion was poor. She had a constant feeling of weakness; was

prone to attacks of palpitation, which might come on even while in bed. Had been attending the Outdoor Department of the Woman's Hospital off and on for four years, receiving only temporary relief. On examination the uterus was found rather low down, but in anteversion. Its mobility was very much restricted, owing to thickening and shortening of the utero-sacral ligaments. Right ovary was moderately swollen, very tender, and pretty firmly fixed to the left side of the pelvis (see Fig. 3). She was submitted to pelvic massage every other day until February 23d, and received ten applications in all. Already after the third *séance* the pain in the back had permanently disappeared, but the pain in the left groin continued off and on for some time after. March 20th: Had been free from all pain since the last date until two days ago, when, after unusual exertion, the pain in the left groin returned. Massage was again applied,

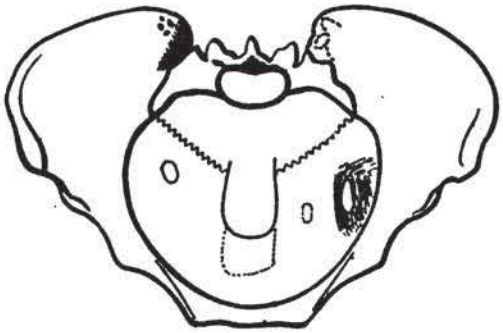

FIG. 3.

and within a week the pain in the left groin vanished. At this time the uterus was freely movable and could easily be brought forward to the abdominal wall. The left ovary was about the normal size, not at all tender, and remained about midway between the uterus and the side of the pelvis (see dotted outlines in Fig. 3). The patient remained under observation until July 19th, 1892, and the condition of the pelvic organs continued about the same as just noted, but the palpitation of the heart still annoyed her from time to time. I could detect no organic disease of the organ, and could only attribute the functional disturbance to what is known as an "irritable heart."

CASE V. *Retrodisplacement of the Uterus, with Posterior Fixation; Thickening of both Broad Ligaments; Thickening of Left Tube; Swelling and Fixation of Left Ovary.*—T. T., æt. 26 years, a very thin and delicate-looking girl, had been my

patient, at various times for the past three years, for debility and general ill-health. She was a dressmaker, had to work hard to earn a livelihood, and three or four times a year would be so run down as to be compelled to give up work for a few weeks and put herself under treatment, which consisted of rest and good food. I had not seen her for nearly a year, when she again presented herself for treatment on January 2d, 1891. Five months before that she had married, and ever since then had pain in the back and pain in the left groin. Her periods were regular, but rather profuse, and were attended with severe bearing-down pains and cramp-like sensations in the abdomen. She had considerable leucorrhea, and her general condition was

FIG. 4.

miserable in the extreme. She looked like a person in the last stage of consumption, but a careful examination could detect no pulmonary affection. Heart, liver, and spleen were also found normal. On examining the pelvic contents the uterus was found retroplaced and rather firmly fixed by a wide band passing to the sacrum. Douglas' space was shallow and tender to the touch. Both broad ligaments were considerably thickened. The left tube was about double its normal size, and the corresponding ovary was the size of a walnut and fixed to the left side of the posterior segment of the pelvis (see Figs. 4 and 5). The patient was put on tonics and subjected to pelvic massage three times a week.

January 28th: Very much improved in every respect. Has no pain anywhere. Uterus freely movable in every direction, but still lies in the posterior segment of the pelvis. No thickening detected in either broad ligament. Left tube still seems thicker than normal. Left ovary freely movable and about half of the size it was when first subjected to pelvic massage (Fig. 6).

November 30th: Patient came to-day, saying she had been very well and had passed thirteen days beyond her expected period. The uterus was found slightly enlarged and lying in retroposition, but freely movable.

She went on to full term, and was delivered of a healthy female child July 25th, 1892. Her puerperium was smooth, but I kept her in bed until the fourteenth day. She was about for two weeks, feeling quite well, when she was seized with pain

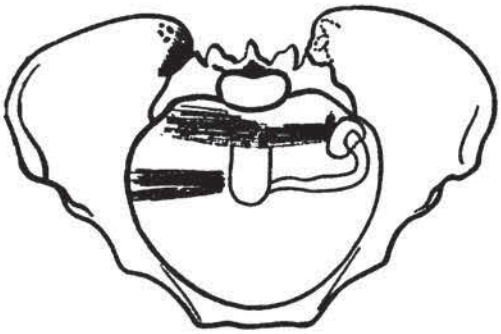

FIG. 5.

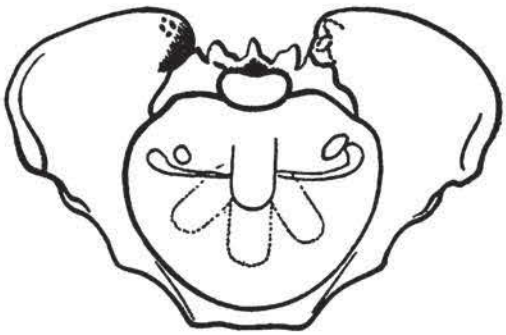

FIG. 6.

and fever, and developed a perimetritis, from which she gradually recovered. The discussion of the cause and nature of this attack is not within the province of this report.

CASE VI. *Prolapsus of Uterus of First Degree; Thickening of Left Tube.*—C. M., æt. 33 years, came under treatment November 26th, 1890. She had been married eleven years and had four labors, the last labor, ten months before, being attended with triplets. After that she had two miscarriages, last one about four months ago. Since her last miscarriage she has suffered from a constant pain across the hypogastrium and from a severe burning sensation in the vagina. Her menses have become very profuse and are attended for the first two days with very great pain. In the intervals of menstruation she has a profuse greenish-yellow discharge. On examination the uterus is found low down, so that the os almost appears at the vulva. It is in anteversion, very large, but freely movable. Left

tube is slightly thickened. No disease other than this detected in the adnexa. Patient subjected to daily massage.

December 25th: Has just passed her period, which was moderate in amount and quite free from pain.

January 12th, 1891: Patient has been free from pain and from the burning sensation in the vagina for over a fortnight. Uterus lies in anteversion and is about the normal size. The os is felt from two and one-half to three inches beyond the vaginal entrance.

May 10th: Saw the patient again to-day. Found uterus of normal size and in about the same position as last noted. Patient has been quite free from any pelvic symptoms.

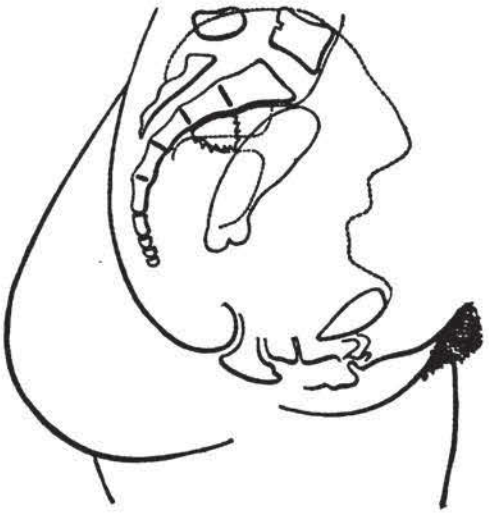

FIG. 7.

FIG. 7a

CASE VII. *Retrodisplacement of Uterus; Shortening of Utero-sacral Ligaments.*—K. A., æt. 29 years, came to me for treatment on February 4th, 1891. Her history, briefly, was as follows: She had been married for five years. Shortly after marriage she had a miscarriage, and ever since that suffered from very severe pain in the back and from almost constant pain in the left groin. The slightest exertion tired her. When walking she felt a heavy weight in the abdomen and the pain in the groin became more severe. Latterly her menstruation grew to be very profuse; was accompanied by a great deal of pain and the passage of several clots. She was growing quite despondent and appeared dull and listless. An examination showed the uterus

to be anteflexed, lying quite high in the pelvis and quite close to sacrum. Both utero-sacral ligaments were tense, cord-like, and quite tender. There was some thickening of the left broad ligament (Fig. 7).

April 25th: Patient has been treated by pelvic massage from three to four times a week since February 4th, excepting an interruption of three weeks in March. Her symptoms have varied from time to time, but marked improvement was manifest from the outset. For the past three weeks she has been free from pain and has been feeling quite well. Her last period was normal in amount and *quite painless.* The uterus is freely movable, lies in fairly good position, and the utero-sacral ligaments appear quite normal (Fig. 7*a*). After this I lost sight of the patient.

Case VIII. *Retroversion, with Adhesion of Cervix anteriorly; Posterior and Lateral Perimetritis; Fixation of Left Ovary in Douglas' Space.*—M. A., æt. 24 years, married eighteen months, had one child nine months ago. The labor was difficult, but no instruments were used. On the third day after labor she had fever which continued for some days. She got up on the ninth day, but had to take to her bed five days later on account of pain, chills, and fever. Kept her bed this time for over three weeks, and could not leave her room for five weeks more. Ever since suffers from pain in the left groin and across the hypogastrium. Every few days there is an exacerbation of pain, necessitating her stay in bed for one or two days. Her menstruation is very profuse, lasting from ten to twelve days, and is attended with very much pain. Profuse leucorrhea and frequent but not painful micturition. Has never, to her knowledge, had a discharge of pus from the vagina or rectum. She first consulted me November 17th, 1891. On examination the uterus was found rather large, in complete retroversion, the cervix pointing toward the pubes. It was easily brought into anteversion, but in this position the Douglas' folds were felt to be very tense. Left ovary was considerably enlarged and fixed in Douglas' space. There was considerable thickening of the right broad ligament (Fig. 8). Pelvic massage to be applied daily; uterus to be kept forward, in the intervals, by glycerin tampons.

November 23d: Pain entirely gone. Is enabled to attend to her household duties, which she has not been able to do since

the birth of her child. Uterus retains the position of anteversion. Left ovary seems to be about the same size, but can be moved considerably.

December 27th: Last two periods have been normal in amount and accompanied by slight pain only during the first day. Has been quite well in every respect. No leucorrhea. Uterus in anteversion. Left ovary, about the normal size, is very freely movable, but has a tendency to prolapse back into Douglas' space. No adhesions or thickening to be detected anywhere in the pelvis (Fig. 9).

November 14th, 1892: Called on patient to-day. She was hard at work washing. Said she had been quite well since last seen by me.

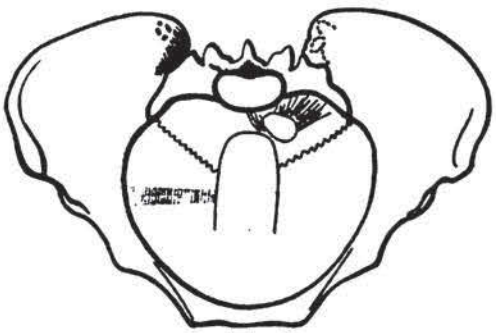

FIG. 8.

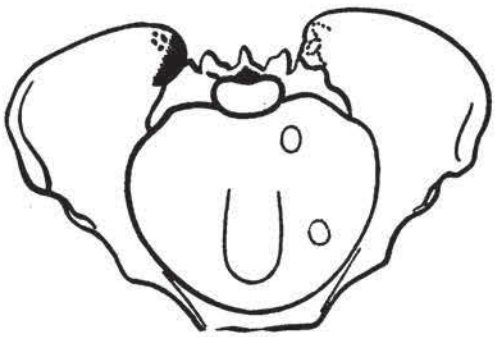

FIG. 9.

CASE IX. *Retroflexion; Subinvolution; General Perimetritis.*—C. A., æt. 20 years, came to me November 19th, 1891. She lived in the same house as the last patient and had a somewhat similar history. She had been married nineteen months and had one child 8 months old. Her labor was difficult, but not instrumental, and on the fifth day of the puerperium she was seized with a chill, which was followed by fever, but not by any great degree of pain. She got up on the tenth day, though feeling very feeble. As far as she is aware, she had no fever after this, but in a short time began to suffer with pain in the left iliac region. This pain was constant and at times very severe. Occasionally she had pain in the right iliac region. There was an abundant greenish-yellow discharge from the vagina, but the menses had not reappeared. She was still nursing her baby. On examination the vaginal vault was found to be shallow and tense, and only a short cervix, with rather a deep bilateral laceration, could be felt projecting beyond the vault. It was extremely difficult, at first, to outline the body

of the uterus, so soft was it; but after applying massage for a few minutes it could be felt to grow hard under the hand and become definitely outlined; continuing with the massage, the uterus could be felt to undergo distinct contraction and to grow appreciably shorter and thicker. It was retroflexed. The uterus was adherent posteriorly by extensive loose adhesions and could not be raised beyond the promontory. The right ovary was normal in size and in position. The left ovary was indistinctly felt in the left side of the pelvis within a mass of thickened tissues, presumably the left ligamentum latum (Fig. 10). Patient subjected to daily pelvic massage.

November 26th: Body of uterus more distinct and somewhat more movable, but cannot as yet be brought into anteversion. Subjective symptoms about the same.

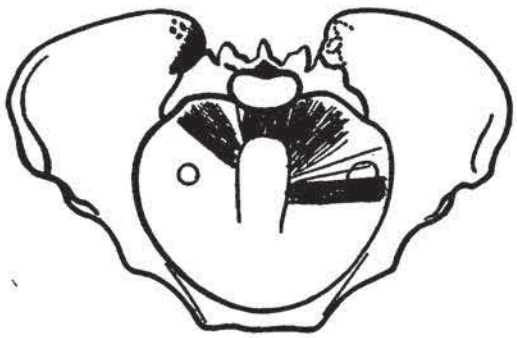

FIG. 10.

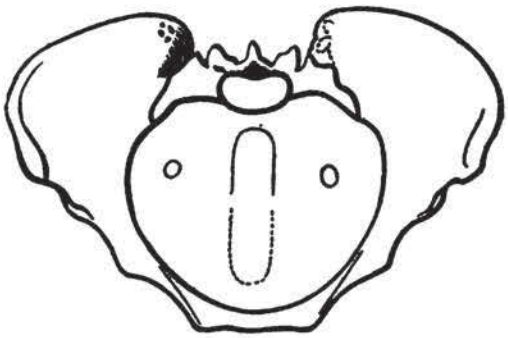

FIG. 11.

November 30th: Succeeded in anteverting the uterus for the first time.

December 15th: Patient free from pain and has lost her vaginal discharge. Uterus readily anteverted, but falls back into retroflexion almost immediately afterward; tried to keep it in anteversion during the past week by various kinds of pessaries, but failed. All other pelvic lesions have disappeared (Fig. 11). As patient was feeling quite well, advised the discontinuance of any kind of treatment.

April 24th, 1892: Patient called to-day and stated that she had remained quite well and that she had passed her expected period for fourteen days. Uterus was found in retroflexion and is readily anteverted; Hegar's sign is quite distinct. Introduced a Smith pessary with the hope of keeping the uterus forward.

June 5th: Uterus in anteversion and about the size of a cocoanut. Removed pessary.

November 14th: Called on patient to-day. Found her at the washtub and in the enjoyment of good health. Expects to be confined in a month.

CASE X. *Retrodisplacement of Uterus; Inflammation of Utero-sacral Ligaments.*—K. M., æt. 23 years, single, had been treated for over a year at a well-known gynecological service before coming to me on May 12th, 1892. In addition to dysmenorrhea she suffered from a severe backache, which was worse at night, and which gave her the sensation as if "a ball of fire" were lying over the lower part of the sacrum. In consequence of this pain her nights were disturbed and she could not sleep more than a few hours each night. Her general health was beginning to suffer, and she was growing despondent through fear of being compelled to give up the vocation by which she earned her living.

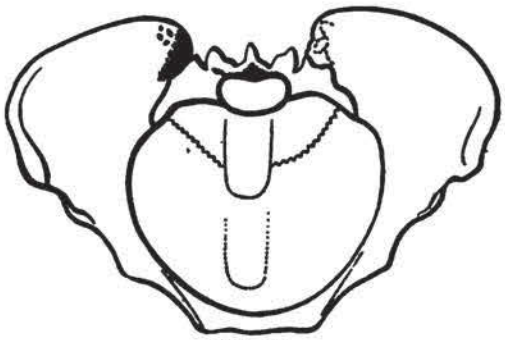

FIG. 12.

An examination revealed a long, narrow cervix with an acutely anteflexed fundus. The uterus lay far backward. Both utero-sacral ligaments were very much thickened and were very sensitive. The most gentle attempt to draw the uterus forward with the finger in the vagina caused considerable pain in the back. No appreciable disease of the adnexa could be detected (Fig. 12).

May 18th: Patient has had daily pelvic massage (six *séances*). She no longer suffers from pain in the back; can now sleep the night through, and as a result of this her general health is improving. Uterus can now be moved in all directions and brought to the symphysis pubis (see dotted outline, Fig. 12) without causing her any pain.

November 1st: Saw patient again to-day. Pain in the back has not recurred. Her general health is good. Mobility of uterus unimpaired.

(To be concluded.)

TWO YEARS' EXPERIENCE WITH PELVIC MASSAGE IN GYNECOLOGICAL CASES, WITH REPORTS OF CASES.[1]

BY

HIRAM N. VINEBERG, M.D.,
New York.

(With twenty-nine illustrations.)

(Concluded.)

CASE XI. *Left Salpingitis and Oöphoritis following a Suppurative Exudation the Result of an Induced Abortion.*—A. G., æt. 19 years, single, was first seen by me on August 9th, 1892. She was then suffering from high fever and an extensive pelvic exudation crowding against the rectum posteriorly and filling the lower part of the pelvic cavity. This condition was the sequence of an attempt to bring on an abortion at the second month by a doctor in the country, and the subsequent efforts of

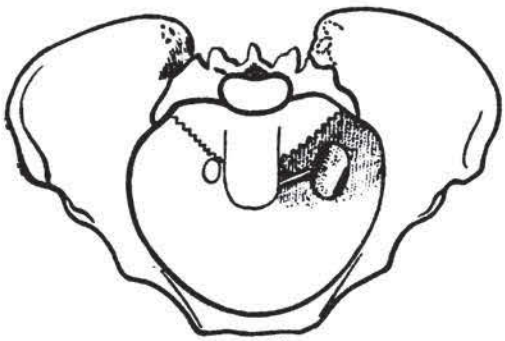

FIG. 13.

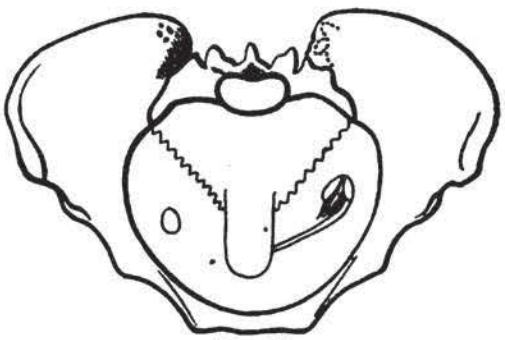

FIG. 14.

a midwife in the city to remove the products of gestation, which she said she had successfully achieved. As any operative interference was stoutly objected to by the patient and her mother, I had to content myself with applying narcotics, hot douches, fomentations, etc. Eight days later the patient passed a large quantity of pus per rectum, and the pelvic exudation underwent a considerable reduction in size..

August 22d: Patient walked to my office to-day. Says she is quite free from pain. Examination shows that the vaginal

[1] Read before the Section on Obstetrics and Gynecology of the Academy of Medicine, November 25th, 1892.

vault is tense and unyielding, and that there is still a considerable exudation behind and to the left of the uterus. The exudation seems to be continuous with the bony structure of the pelvis.

September 12th: Has had vagino-abdominal galvanism thrice weekly since above note. Exudation has shrunk to a mere thickening in Douglas' sac and left parametrium. Patient feels quite well and has not an ache or a pain.

October 8th: Returned to-day, saying that for the past few days has had pain in the left iliac region. On examination uterus was found retrodisplaced and restricted in its movements by bands passing to the sacrum. There is a fulness felt to the left of the uterus, in the centre of which an oblong mass can be outlined, probably the left tube and ovary. The right ovary is adherent to the side of the uterus at the junction of the cervix with the body (Fig. 13). Patient was now subjected to daily pelvic massage.

October 22d: The pain in the left iliac region disappeared after the third *séance*. The uterus now is freely movable. The left parametrium seems to be free from any thickening, and the left ovary can be readily made out. It is perhaps somewhat larger than normal. Right ovary lies about midway between uterus and side of pelvis (Fig. 14).

Case XII. *Prolapsus of the Uterus of the First Degree.*—L. D., æt. 30 years, married twelve years, came under my care August 12th, 1892. Has one child 11 years of age. Menstruation set in at the age of 17; was scanty, and recurred only every five or six weeks. It was quite painless. Her labor was easy and her recovery good. She did not menstruate until her baby was 19 months old, and now for the first time the flow was attended with considerable bearing-down pain, which continued during the menstrual flow. From this on the flow grew more scanty, lasting only a day or thirty-six hours. Nervous symptoms common to the climacteric began to manifest themselves. There was a fulness in the head, flashes of heat, flushing of the face, etc. She was treated for a time with galvanism over both ovaries, without, however, increasing her flow or relieving her symptoms. In addition she suffered from a feeling of weight over the hypogastrium and from a frequent desire to urinate. For the latter symptoms two operations (nature of which the patient did not know) were done at different times at the Bellevue Hospital. No benefit resulted from these operations.

The patient is a robust, healthy-looking woman, with thick but lax abdominal walls. The uterus is small, anteflexed, lying low down in the pelvis, with the fundus resting on the bladder; it is freely movable. In the erect position the cervix is felt an inch above the vaginal entrance (Fig. 15). The appendages are in fairly good condition, the left ovary being somewhat large but freely movable. In addition to intra-uterine negative galvanism to increase the menstrual flow, the patient was subjected twice weekly to pelvic massage. This consisted chiefly in elevating the uterus as high as possible with the two fingers in the vagina, ending with a vibratory movement.

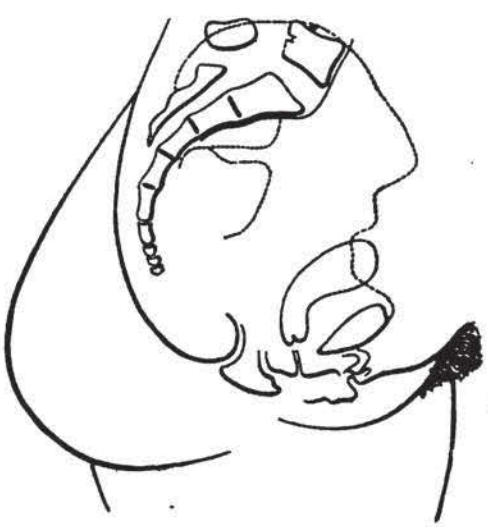

FIG. 15.

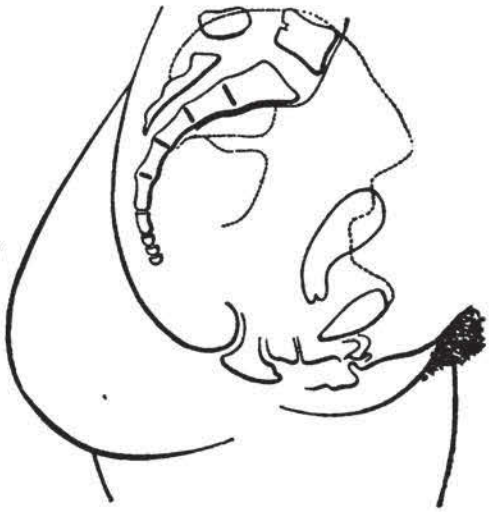

FIG. 16.

October 7th: The symptoms of weight over the hypogastrium and the desire to urinate frequently have disappeared. The nervous symptoms still persist, though in a diminished degree. The uterus lies at least two inches higher up in the pelvis (Fig. 16).

November 12th: Has just passed a period. The flow was more abundant (lasting from three to four days) than it has been for years. Nervous symptoms all gone.

CASE XIII. *Retroflexion; Chronic Metritis, with Softening of Isthmus; Prolapsus of Right Ovary; Thickening of Left Broad Ligament.*—Mrs. B. consulted me first on August 15th, 1892. She was 28 years of age, married at the age of 18, and had two children, last child 6½ years of age. Three years ago

she induced an abortion at the sixth week of gestation. She dates her symptoms from the birth of her last child. These consist of pain in both iliac regions, severe backache, inability to walk for any distance or to stand for any length of time, inability to do her housework, leucorrhea, and frequent micturition. Last winter, while wearing a pessary, she was seized with acute pain in the pelvis and had to remain in bed for three weeks. She had been treated by various specialists, some of whom were of high standing, for the past six years. Two years ago a well-known gynecologist carried out Schultze's method of redressing the uterus under deep narcosis. This was said to be successful,

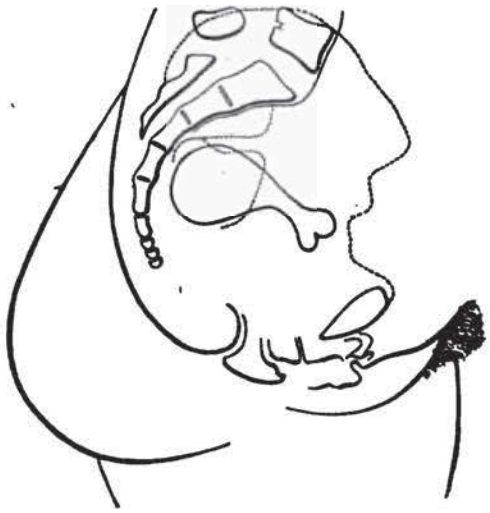

FIG. 17.

but the patient says her symptoms were worse after the operation. No method of treatment, she asserts, has given her much relief, but she always felt better while medicated tampons were placed in the vagina.

The patient is of spare build, rather anemic, and poorly nourished. The digestion is poor and her bowels are constipated most of the time. On examination the fundus of the uterus, considerably enlarged, globular in form, is found lying in the hollow of the sacrum and is moderately retroflexed. The cervix points toward the pubes and is separated from the fundus by a thinned portion simulating Hegar's sign. The fundus is widely adherent to the sacrum, but can be brought forward as far as the promontory. The right ovary, the size of a walnut, lies in

Douglas' space at the right side of the uterus, and is extremely tender. There is considerable fulness and thickening on the left side, and neither tube nor ovary can be detected (Figs. 17 and 18).

August 22d: Has had four *séances* of pelvic massage. The uterus can be anteverted, but not without some difficulty. Right ovary less tender and somewhat smaller.

September 1st: Uterus can be easily anteverted, but always found in retroversion at the next visit. Patient's symptoms vary. At times she feels better, at other times has the same complaints to make. The thickening on the left side has disappeared in a great measure, and the left tube, the size of a goose quill, can be readily palpated. The left ovary is felt next to the left pelvic wall, pretty far forward, and is rather firmly fixed.

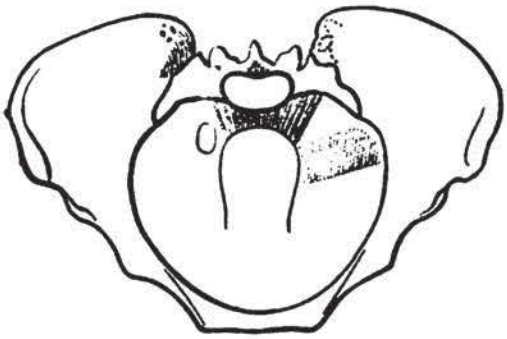

FIG. 18.

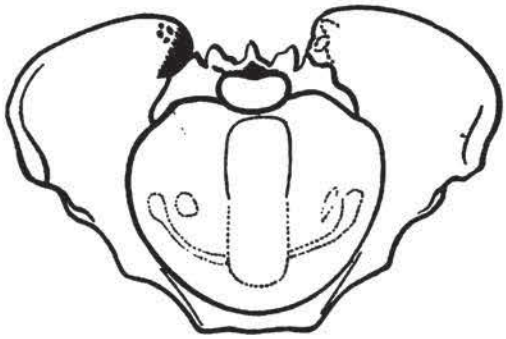

FIG. 19.

September 10th: The uterus still persists in reverting to its faulty position. The left ovary is now freely movable. The right ovary is very much smaller in size and can be freely palpated without giving pain (Fig. 19).

Patient declines to continue with treatment, partly on account of the distance she has to come (living on the outskirts of Brooklyn), but chiefly on account of pecuniary reasons. She thinks, also, that she has not made sufficient progress, for on doing her household work, which she was unable to do before, many of her former symptoms return. On the whole, she confesses to be considerably improved.

CASE XIV. *Retroversion; Adhesion of Cervix anteriorly; Prolapsus of Right Ovary; Fixation of Left Ovary to Pelvic Wall.*—M. K., æt. 23, single, came to me for treatment August 28th, 1892. She menstruated at the age of 14, and for the first two or three years irregularly, but the flow was abundant from

the outset and was accompanied by considerable pain. The pain would come on the day before the flow and continue during the whole period.

About two and one-half years ago, on lifting a heavy weight, she was seized with acute, agonizing pain in the left side of the pelvis, which lasted for several hours. Ever since that time she has suffered from pain in the left iliac region, backache, frequent micturition, leucorrhea, and inability to perform active exercise. Walking only a short distance fatigued her and caused an exacerbation of the backache and the pain in the left side. Had been treated for over eighteen months by hot douches, painting of the vaginal vault with iodine, and packing the vagina with glycerin tampons. In spite of persistent treatment her symptoms remained about the same.

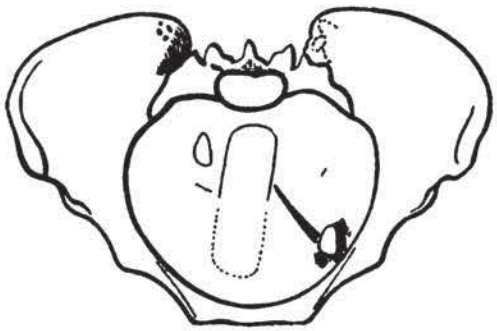

FIG. 20.

On examination the uterus was found lying in complete retroversion, with considerable adhesions between the cervix and anterior abdominal wall. There were little or no adhesions posteriorly, and the fundus could, without much difficulty, be anteverted, in which position the space between cervix and anterior vaginal wall was very shallow and tense. The right ovary was found low down in Douglas' space and slightly adherent. The left ovary was firmly fixed to the left pelvic wall, not far from the symphysis pubis. A firm, stout cord passed from the side of the uterus to the left ovary (Fig. 20).

Patient was subjected to pelvic massage thrice weekly, and an ichthyol tampon was placed behind the replaced uterus after each *séance*.

September 9th: Period has set in *without the slightest pain*. Has been quite free from pain for the past four days.

October 3d: Left ovary freed from its adhesions.

October 18th: Menses appeared yesterday without any pain. Excepting an occasional stitch in the left side, she has been quite free from pain. Takes long walks, and watched every parade during the Columbus celebration without unusual fatigue.

November 8th: No recurrence of former symptoms. Fundus of uterus lies midway between the promontory and the symphysis pubis. Uterus can be moved freely in all directions. Cervix points in the direction of the vaginal outlet. Left ovary felt in about the normal position, and is freely movable. Right ovary lies high up in the pelvis, but posteriorly to the centre of the pelvis (Fig. 21).

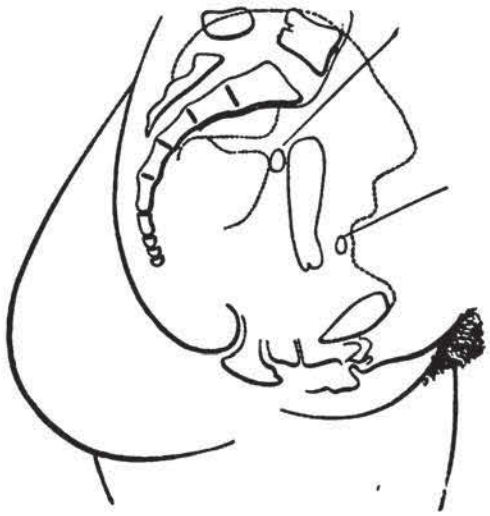

FIG. 21.

CASE XV. *Retroversion with Posterior and Anterior Adhesions; General Perimetritis; Fixation of Left Ovary to Pelvic Wall.*—A. B., æt. 40 years, married twelve years, came under my care August 8th, 1892. She had three children, last child four years ago. Had one miscarriage at the third month seven years ago. Dates her trouble to the birth of the last child. She has severe pain all over the pelvis, but it is most constant and pronounced in the right iliac region. Has constant backache. Her general health has suffered, and she has lost considerable in weight. She has been going to doctors and dispensaries for over three years, but has received no relief. She is a small, thin, wiry-looking woman. Her abdomen is moderately lax; some displacement of the right kidney is detected. The uterus is retroverted. The fundus is large and globular, and lies in the

hollow of the sacrum; it is moderately adherent. The cervix points to the pubes and is slightly adherent to the anterior abdominal wall. There is considerable thickening to the right of the uterus, making it difficult to detect either right ovary or tube. A similar condition exists on the left side, but the left ovary can be felt fixed to the side of the pelvis (Fig. 22).

August 20th: Has had daily pelvic massage. Patient quite free from pain. Little or no thickening now on either side of the uterus. Left ovary in normal position. Right ovary in Douglas' space, to the right of the uterus. The uterus can be easily anteverted, but is usually found in retroversion at the next *séance*.

October 24th: Excepting for an occasional pain in the right groin, patient has remained free from pain. She is feeling very much improved in every way. Right ovary now lies well for-

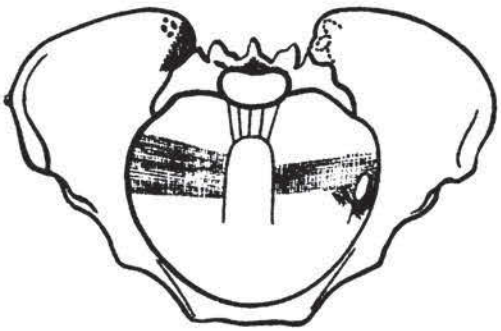

FIG. 22.

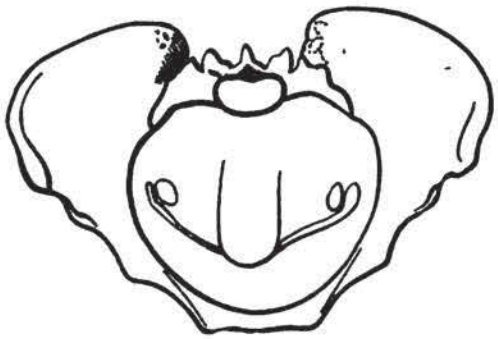

FIG. 23.

ward and high up in the pelvis. No thickening on either side of the uterus. The uterus still has the tendency to fall backward (Fig. 23). Introduced a Smith pessary.

October 25th: Fundus lying over posterior bar of pessary. Adjusted a larger pessary.

October 28th: Uterus well retained. No pain whatever. Has no discomfort from pessary.

November 8th: Uterus held in good position by the pessary. Has just had period, which was painless, as was also the period before.

CASE XVI. *Retroflexion; Chronic Metritis with Softening of Isthmus; Prolapsus of Right Ovary; Fixation of Left Ovary to Psoas Muscle.*—K. S., æt. 39 years, married nineteen years, was first seen by me August 23d, 1892. She had four children, last child five years ago. Following the last labor she had fever, and pain in the pelvis, and was quite ill for a fort-

night. Ever since then has been a great sufferer from pain in the pelvis, dysmenorrhea, leucorrhea, severe backache, and a variety of nervous symptoms. Her digestion is poor; has eructations, flatulence, constipation, etc. Has been under steady treatment for the past three years. Visited one physician regularly for a year, but was no better at the end of the year than when she began. Another physician introduced a pessary, which almost drove her frantic with nervous irritability and a feeling of discomfort in the pelvis. Was advised to see a neurologist, but, believing her nervous irritability due to the pessary, she removed it and felt considerably relieved.

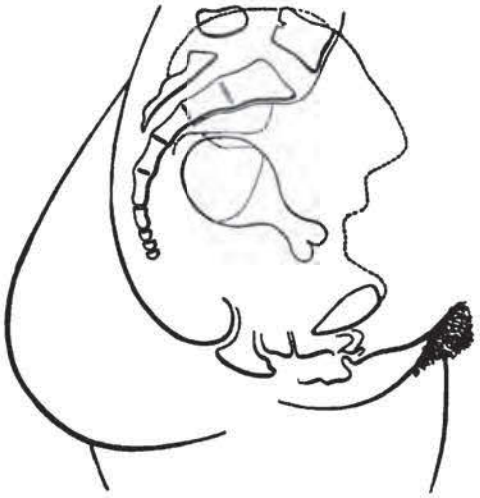

FIG. 24.

She is a thin, lightly-built woman, with a haggard expression and pale face. The uterus is retroflexed and somewhat adherent posteriorly. The fundus is large and globular in form, and is separated from the cervix by a thinned portion similar to that in Case XIII. Right ovary is the size of a walnut, and is prolapsed in Douglas' space, but is quite movable. Left ovary lies on the left psoas muscle and is firmly fixed (Figs. 24 and 25).

September 2d: Has had pelvic massage thrice weekly. The uterus is easily anteverted, and is kept in anteversion in the intervals by ichthyol tampons.

October 7th: Patient has been fairly regular in attendance. She has less pain, but is far from feeling well. Her general condition and nervousness remain unchanged. Locally there is marked improvement. The fundus is considerably smaller and

is easily brought forward. The right ovary is almost of normal size and lies higher in the pelvis, though still posteriorly to the central line. Left ovary is freely movable, is not sensitive, and lies midway between uterus and wall of the pelvis, the uterus being in anteversion (Fig. 26).

October 31st: Patient's symptoms continue about the same. Has profuse leucorrhea. Advised curettage for the endometritis; I am of the opinion that this would benefit her very much, as her symptoms can no longer be dependent upon pelvic adhesions.

Case XVII. *Firm Fixation of Uterus to Rectal Wall; an Irregular Mass attached to Fundus posteriorly.*—M. S., single, æt. 35, consulted me August 19th, 1892. Her illness began seven years ago with irregular menstruation, pain in the abdo-

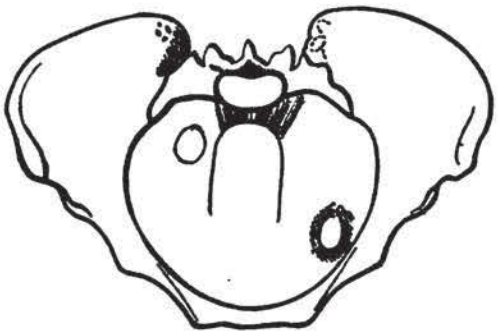

Fig. 25.

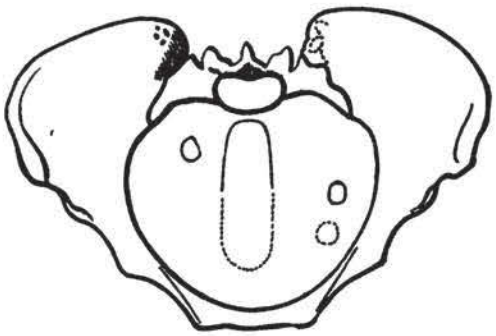

Fig. 26.

men and back, constipation, and general debility. After a year's treatment the menses became regular, but all her other symptoms have continued, with varying intensity, until the present time. She has been seen and treated by many of our best gynecologists; has been a faithful attendant, for a year at a time, at some of our best dispensaries; but the relief obtained was only slight and of but temporary duration. Five years ago she attended for a considerable time Dr. James B. Hunter's service at the New York Polyclinic. I was then Dr. Hunter's clinical assistant, and remember having seen and examined her on several occasions. She was looked upon as a hopeless case, for whom nothing could be done save placing medicated tampons in the vagina, more for the moral effect than for the hope of giving her any relief. At that time the uterus was lying against the rectum, and seemed to be cemented to it, so firm and close were the adhesions. For some weeks before coming to me last

August the pain in the pelvis had been unusually severe, and she was so run down on account of this that she had to give up her position as seamstress in a well-known establishment. She was very much depressed in consequence, and had but little courage to recommence treatment, which, as her past experience had taught her, did not offer bright prospects. I must confess that, after examining her, it was with a faint heart that I suggested a trial of pelvic massage. The uterus was found slightly enlarged, lying somewhat left of the median line, and in complete retroversion. The cervix, which was small and atrophied, pointed to the pubes. Lying closely on the sacrum, and firmly fixed to it, was an irregular mass, double the size of the normal

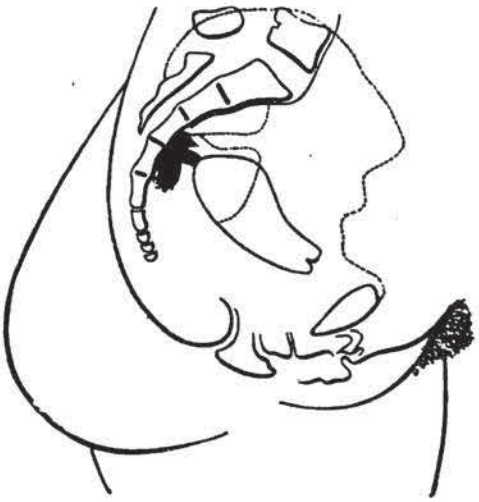

FIG. 27.

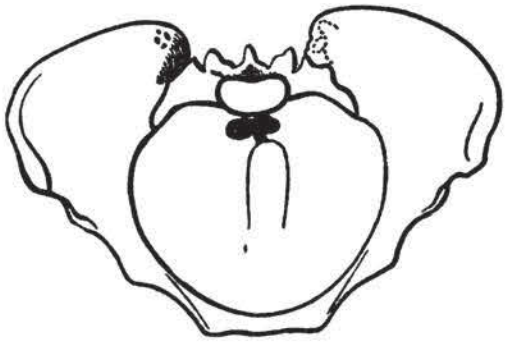

FIG. 28.

ovary, and not especially sensitive. This mass was attached to the fundus by a firm cord about one inch in length and of the thickness of the little finger. The abdominal walls were moderately thin and not at all rigid, so that the pelvic contents could be readily palpated. But I could find nothing in the pelvis other than that described above, and came to the conclusion that the mass and cord behind the fundus were the tubes and ovaries matted together (Figs. 27 and 28). A specialist of noted diagnostic skill, who had seen the patient a few months before, diagnosticated a fibroid growth. His diagnosis may be the right one, and the inability to find the tubes and ovaries may be due to atrophy of these organs, as the patient has evidently passed into the climacteric for over a year, for her menstruation has been

scanty, occurring only once every six or eight weeks during that period.

September 2d: Has had daily pelvic massage, which has been done chiefly through the rectum and abdominal wall. The attempts at loosening the mass from the sacrum are attended with considerable pain, which, however, immediately passes off. Patient has been free from pain for two days. Has gone back to work. Says that she wakes up with a start several times during the night; thinks this is due to the treatment.

September 15th: With a single exception of one day, patient has had no pain whatever since last note. The treatment has only been applied every other day. Is beginning to feel much

FIG. 29.

stronger, and no longer feels that unbearable fatigue at the end of the day's work which was her wont for several years.

September 22d: Succeeded to-day in getting uterus and attached mass as far forward as the promontory. Patient declares she has not felt as well for three years. Although the stretching of the adhesions and the lifting or elevating of the mass and the uterus are attended with acute pain, she is very faithful in her attendance and comes as often as told to.

October 15th: Got mass up beyond the promontory to-day. Patient continues free from pain and is gaining in strength and in flesh. During the past week the bowels have moved spontaneously on two different days; prior to that had not a spontaneous action of the bowels for years—not, she thinks, since her

illness began seven years ago. She tells me also that now a smaller dose of a purgative has the desired effect.

November 13th: Since last note patient has had treatment only once a week. About a fortnight ago had some pain in the left groin and hip, but this was slight and passed away after a treatment. There is considerable mobility of the uterus and attached mass, and on one occasion I succeeded in bringing it almost as far as the pubes (Fig. 29). General condition is much improved. Save the two exceptions noted of about a day each, for two months and a half she has experienced entire freedom from pain and has not felt as well generally for over seven years.

The results obtained by Boldt and myself in this country and by numerous operators abroad I think justify the following conclusions:

1. Pelvic massage is a most valuable therapeutic measure in a large percentage of gynecological affections.

2. If properly applied, in the cases where it is indicated, it is a thoroughly safe procedure.

3. Cœliotomy and ventro-fixation for displacements of the uterus and for residua of inflammatory processes are unjustifiable until the case has first been subjected to a thorough trial with pelvic massage.

4. It must entirely replace Schultze's method, which is a dangerous procedure, limited in its application, and is not nearly as efficient in breaking up adhesions of long standing.

5. Of all methods and surgical procedures for the treatment of adherent and displaced pelvic organs it must rank as the *ideal* one, calling for no mutilation and for no fixation of organs. The latter is in itself pathological, as Nature has given these organs, especially the uterus, a wide range of mobility.

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