EDITORIALS

SURGERY, GYNECOLOGY AND OBSTETRICS

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FEBRUARY, 1925

DISASTERS FOLLOWING OPERATIONS FOR RETROPOSITION OF THE UTERUS

WITHIN the last month, my attention has been called very forcibly by three cases which have occurred in my own clinic to disasters which follow operations for retroposition of the uterus.

I shall first briefly describe these cases and then attempt to draw a moral from them:

CASE 1. A woman of thirty, very anxious to have children, was operated upon by a competent gynecologist in Boston, who sewed the fundus of the uterus to the anterior abdominal wall with a silk suture. This was done some months ago. I was called to see her in a very acute attack of intestinal obstruction. She had been writhing in pain for a few hours. I made an immediate laparotomy and found the entire sigmoid strangulated and almost black, the entire loop having been caught between the uterus and the anterior abdominal wall and strangulated by a fibrous cord extending from the uterus to the abdominal wall which contained a silk ligature. This fibrous cord was removed with the ligature and after watching the intestine, wrapped up in moist pads, for 15 minutes the color improved and I decided not to make a resection, but to place the sigmoid back in the abdominal cavity. Fortunately, she went on to a good recovery.

CASE 2. Within two weeks, another young woman who had had several children, and who had been operated upon by a prominent gynecologist in Chicago, was seized with a similar attack of acute intestinal obstruction late one evening. I saw her the next morning and had her removed at once to the hospital. I did a laparotomy and found about two feet of the ileum strangulated in a band of adhesions extending from the round ligament to the anterior abdominal wall. This band was divided and removed. Although the loop of strangulated gut was a very dark, purple color it finally improved and the intestine was placed back in the abdominal cavity. She fortunately went on to a good recovery.

CASE 3. Within the past few weeks a third patient came to me who had been operated upon by a competent surgeon in Cincinnati. She had had some perineal repair work done and had had the uterus brought forward by fixing the round ligament to the anterior abdominal wall, pushing a loop of round ligament through the musculature. At the site of each operation a large hernia had developed. I operated under ethylene and found a hernia as large as a good-sized orange on one side, and on the other a hernia about the size of a lemon. The hernial sacs were removed and a careful dissection made so that we could close the wound as we do in a muscle-splitting operation for appendicitis.

The lesson of these three cases I think is evident. No surgeon has a right to perform an operation for fixation of the uterus that carries with it the dangers that developed in these three cases. I have seen in the course of my work fifteen or twenty cases of obstruction following operations for fixation of the uterus. Other surgeons must have had the same experience, and these facts must be generally known. I believe that the time has come when we must eliminate entirely from our abdominal technique operations of this type just as we have generally eliminated chloroform from the field of anæsthesia because

of the very definite risks which these operations carry with them. There is, however, a more fundamental fact which should be generally known and generally accepted, and that is that there is no logical reason for operating on retropositions of the uterus which are not associated with other pathological conditions.

Thirty years or more ago as a young surgeon I was very skeptical about the local and general symptoms which were attributed to the condition of retroposition of the uterus. I could not understand how a mobile retroposed uterus could produce symptoms any more than a mobile sigmoid which might fall backward or forward, or to the right or left. I soon found that the cases which I operated on and brought the uterus forward in the supposed normal position were not only not benefited but that many of them were made worse by the operation, and so I early discarded it as unnecessary and illogical.

A number of surgeons who have studied this problem have come to the same conclusion and yet the operation continues to be performed, and every year hundreds and thousands of women are submitted to this unwarranted procedure. The operation is not only unwarranted but it is harmful and dangerous. I know this from the fact that I have seen many women who have been made miserable from bladder and bowel symptoms resulting from plastering the uterus forward in a fixed position and from the fact that I have been compelled to operate on a number of cases of intestinal obstruction following the operation. Looking upon this problem as a piece of scientific clinical research I believe we are today in a position to state that the uncomplicated, movable, retroposed uterus produces no symptoms and that operative procedures on such cases must be emphatically condemned.

An excellent study of this subject has been published recently from the Gynecological Clinic in Giessen by Jaschke in the *Muenchener medizinische Wochenschrift*, May 23, 1924. In this study Jaschke analyzed one thousand cases of retroflexion alongside of one thousand cases of anteflexion and found that the supposed characteristic symptoms of retroflexion, i. e., increased menstrual flow, leucorrhœa, bladder distress, constipation, backache, dysmenorrhœa and sterility, occurred as frequently in supposed normal anteflexion as in the supposed abnormal retroflexion. He comes to the conclusion that the uncomplicated retroflexed mobile uterus produces no characteristic symptoms of any kind and causes no characteristic distress. Where the distress and the supposed classical symptoms of retroflexion are present these are due to complications. These complications are not limited to pelvic peritonitis and adhesions which fix the uterus in retroflexion but are often other pathological conditions in the pelvis and abdomen, lesions of the appendix and cæcum, sigmoid, stomach, kidney, etc. Jaschke gives A. Theilhaber, the Munich gynecologist, credit for having first exposed the fallacy of retroflexion as a pathological entity. For many years Theilhaber's position was not accepted, but time and scientific investigations have proved beyond question that retroposition of the uterus produces no local or general symptoms of any kind; that when symptoms are present with this condition they are due to complications.

These facts are now so clearly established that we must conclude without any reserve that the time has arrived when operations done on women for retroposition of the uterus, for this condition alone, are unwarranted, unnecessary and indefensible because of two facts: that these operations are of no benefit to the patient and they carry with them the

serious risks such as I found in the three cases which I have enumerated.

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