

ABSTRACT OF A PAPER
ON PROCIDENTIA UTERI,

READ BY

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WHENEVER the cervix uteri passes through the mouth of the vagina we call it a procidentia, whether it be to a slight or a great extent.

Several separate and independent conditions must conspire to produce a result so opposed to the designs of nature. Thus, there must always be a broad pubic arch, with very divergent rami and a relaxed perineum; and then the axis of the uterus must be turned back in a line with that of the vagina and the pelvic outlet; in other words, there must be a retroversion. With the uterus anteverted, a procidentia is utterly impossible, be the attendant circumstances what they may.

In an old procidentia the vagina attains enormous proportions, in consequence of its being constantly expanded by the distending power of its hernial contents.

Fig. 1 is from a photograph of a patient of Dr. Thierry-Mieg, in Paris, and represents a cystocele as the first stage of procidentia.

Sometimes we find the intra-vaginal cervix elongated, but

oftener the supra-vaginal. Occasionally we see a complete descent of the whole uterus through the vulva.

But while we only occasionally find a procidentia thus associated with a uterus, under or even of normal size, we often

Fig. 1.



find it where there is hypertrophy of some part of this organ.

In cases of cervical elongation we often find the utero-cervical canal four or five inches deep. This elongation is evidently secondary. I believe it to be a sequence of the procidentia. If the body of the uterus passes out of the pelvis, there is no supra-vaginal elongation; if not, there is.

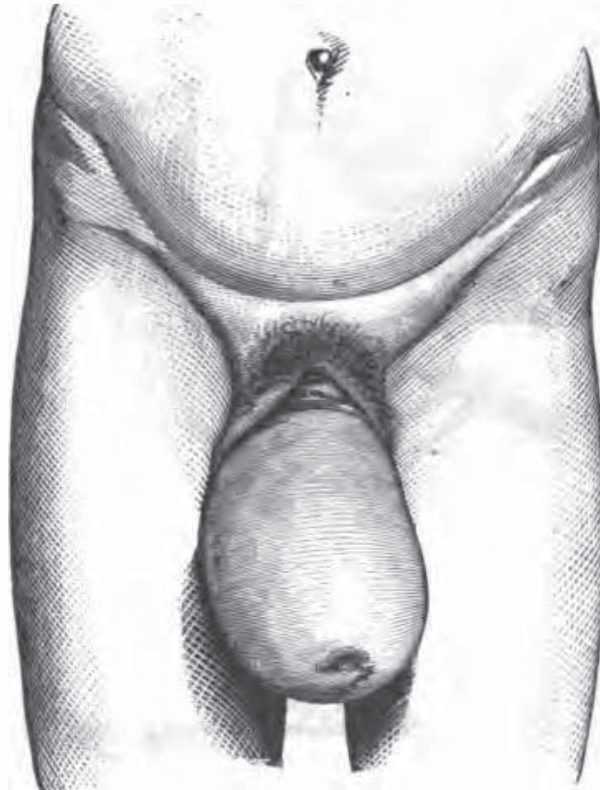
When the procidentia is due to a mass of tumours filling the pelvic cavity, and crowding the uterus downwards, as I have seen in several instances, we cannot, I regret to say, promise much relief.

Fig. 2 represents a procidentia of more than twenty years'

standing, in a woman nearly seventy years of age, whose pelvis was filled with a number of small fibroids of bony hardness.

Huguier has written extensively on procidentia uteri, and I believe he was the first to point out the distinctive charac-

Fig. 2.



teristics of its anatomical peculiarities. He found elongation of the cervix in all cases, either above or below the insertion of the vagina; and he suggested and performed amputation of the neck of the uterus in every case, and with great success.

I amputate the cervix only when its lower segment is too large or too long, and projects so far into the vagina as to present a mechanical obstacle to the retention of the uterus *in situ* when replaced. If there should be elongation of the infra-vaginal cervix, amputation is the remedy; but we often find procidentia without any extraordinary elongation of the

infra-vaginal portion of the cervix. There is then nothing to amputate.

In these cases Mr. Baker Brown, Dr. Savage, and others, contract the vulvar outlet by the perineal operation; but generally I prefer to narrow the vagina above, which usually very effectually retains the uterus in something like a normal position within the pelvis.

The idea of narrowing the vagina is by no means new. I suppose we may justly claim it for the great Marshall Hall. However, I do not think the operation ever succeeded till my own day, and this success is due wholly to metallic sutures.

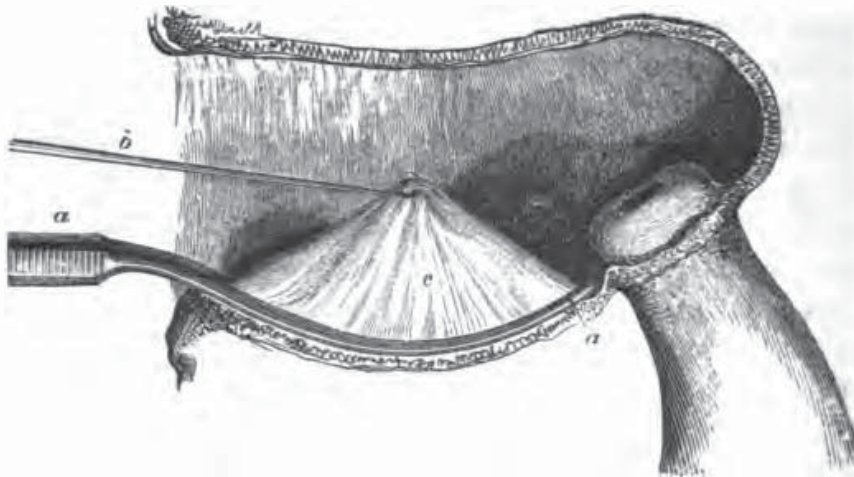
The author then described a case in which he observed that the descent was not by the protrusion of the cervix uteri, but invariably by a prolapse of the anterior wall of the vagina, which always preceded the cervix, and drew down the uterus. He noticed also that, by pinching up the anterior wall of the vagina into a longitudinal fold, the parts had no tendency whatever to come down; and that it was impossible for the patient to force them down if the anterior wall of the vagina was prevented from descending. Hence the idea of removing the redundant portion of the anterior wall of the vagina; but "it did not occur to me to operate simply by removing strips of vaginal mucous membrane. I seriously proposed to this lady to make a complete vesico-vaginal fistula, by removing at one blow, as it were, a large portion of the base of the bladder with the anterior wall of the vagina. She agreed to it, and it was adopted."

Proposing to excise the anterior wall of the vagina, I hooked it up with a tenaculum, pulled it well towards the posterior wall, and then grasped the base of the mass thus elevated with a pair of curved forceps made for the purpose, acting on the principle of Ricord's phymosis forceps, which held the parts firmly embraced, while with scissors cutting under the forceps I removed, at once, a very large portion of the anterior wall of the vagina. The portion removed measured two inches and a half transversely, by two inches and five eighths longitudinally, and was very thick. The chasm made by this operation was fearful, the

lateral retraction of the divided edges being so great as to present at a superficial glance some difficulty in bringing them together by sutures. There was, however, no trouble whatever.

Fig. 3 would represent a side view of one blade, *a*, of the forceps, as it grasped the portion *c*, to be removed. The bleeding was not profuse; but I at once rapidly filled the

Fig. 3.

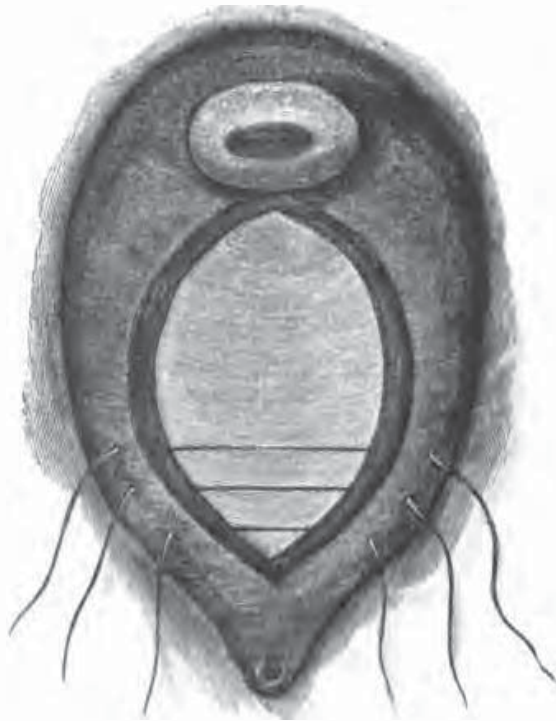


chasm with cotton, to stop the hæmorrhage by pressure. A few minutes sufficed for this; and then the tampon was removed for the purpose of closing the edges of the opening by transverse sutures. My surprise was equalled only by my delight, when I found that I had not succeeded in doing what I intended; for instead of excising the base of the bladder with the anterior wall of the vagina, I had, by the tenaculum, simply raised the hypertrophied vaginal tissue up between the blades of the forceps, luckily separating it from the lining membrane of the bladder, which remained intact. Thus, by a mere accident, the operation was really far better than if I had succeeded in accomplishing what theoretically I proposed to do.

Fig. 4 would represent about the relative proportion of vaginal tissue here removed. The lateral edges were brought together longitudinally by silver sutures passed transversely, as represented in the diagram. She was soon well, and is so to this day. The operation was done nine years ago. This

method of operating was continued till 1858, when an elderly woman, with an enormous procidentia of fifteen or twenty years' standing, was sent to the Woman's Hospital by Dr.

Fig. 4.

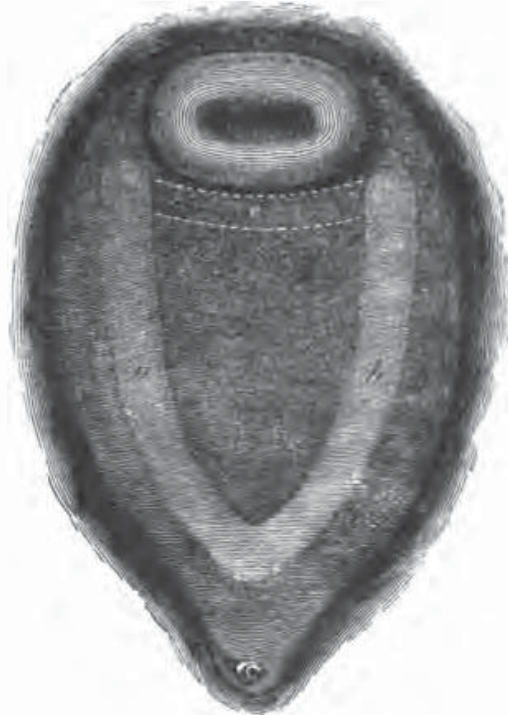


Duane, of Schenectedy. It was a very bad case indeed. I operated by the plan of simple denudation over an immense surface; the parts were brought together and healed kindly; but I had not removed tissue enough, and there was a considerable cystocele left, which required that she should use a pessary; and then it was that I devised another method of operating. Instead of the broad scarification of the anterior wall of the vagina, I simply removed the mucous membrane in the form of a V (fig. 5, *a*, *b*), the apex being near the neck of the bladder, the two arms extending up on the sides of the cervix uteri. These two denuded surfaces were brought together by silver sutures passed transversely, thus making a longitudinal fold narrowing the vagina and crowding the cervix backwards. This simple operation was thus repeatedly performed, and always successfully, by Dr. Emmet and

myself, at the Woman's Hospital, from 1858 to 1862, when I left New York.

In Paris I had occasion to perform it for Sir Joseph Olliffe on an old lady sixty-five years of age, who had had procidentia for twenty years. The parts united; the uterus was held in its place, and she returned home in a fortnight.

Fig. 5.



Her general health was very feeble, in consequence of a long residence in India; and in two months the whole cicatrix gradually gave way, and the procidentia was reproduced. This was the first and only case of failure that I had ever seen after this method. The operation was subsequently repeated; but this time, instead of a V-shaped scarification, it was made in the form of a trowel, as represented in fig. 6, the point presenting below, the shoulders above in the anterior cul-de-sac. The denuded surfaces *a c* and *b d* were brought together by transverse silver sutures. A small portion of tissue was left undenuded at *e*, between *c* and *d*, for the purpose of permitting the escape of any secretions naturally forming in the shut pouch *f*.

The mechanical execution of this operation is a matter of some nicety, but it is by no means difficult. Suppose we have such a case as the one represented in fig. 7, which may be taken as a type of its class; we wish to narrow the vagina to keep the parts in their normal relations. We would suppose, *à priori*, that the operation could be done more easily and exactly with the uterus thus protruded; but it is a great mistake. The uterus must first be restored to its proper position, and if the os tincæ is ulcerated as, here represented, or if

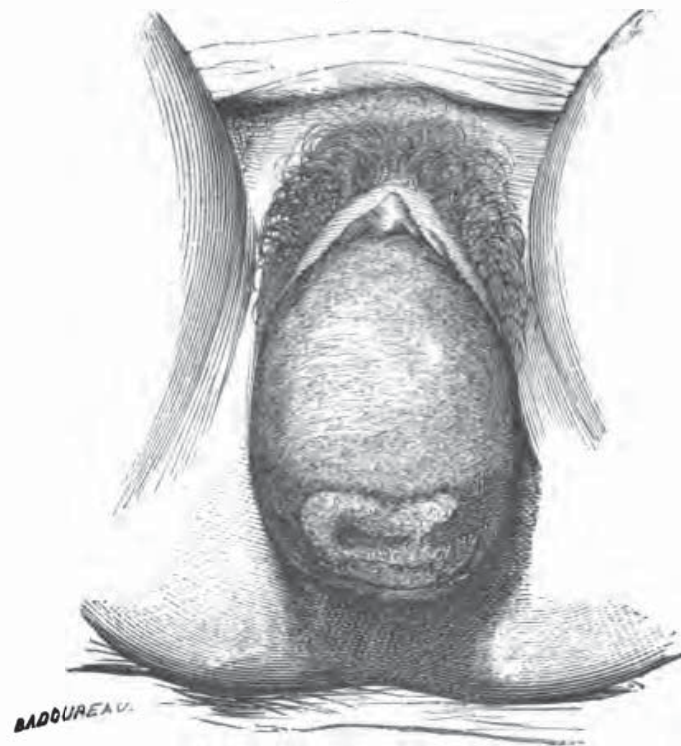
Fig. 6.



the vagina is dry, scaly, and skin-like, it will be well to apply glycerine on a tampon of cotton, for a few days, till the ulcerations are healed and the vagina assumes more of a normal appearance; after which the operation may be performed. For this purpose the patient is to be placed on the left side, with my speculum introduced to pull back the perineum and posterior wall of the vagina. We can then get an accurate idea of the dimensions of the over-distended vagina, and with a small tenaculum hooked into the mucous membrane on

each side of the middle line of the anterior wall we can approximate these surfaces, and thus determine whether we should make the denudation of tissue to a greater or less extent on either side. There was at first some little trouble in making the two arms of the V equilateral; sometimes one would diverge a little more from the median line on one side than the other; but this was overcome by using a malleable uterine sound curved as represented in fig. 8. Its convexity rests centrally along the middle line of the anterior wall the distal end pushes back the cervix uteri, while the counter-curvature lies in contact with the urethra. By thus pushing the neck of the uterus back in a straight line, while the anterior wall is depressed centrally, the curvature

Fig. 7.

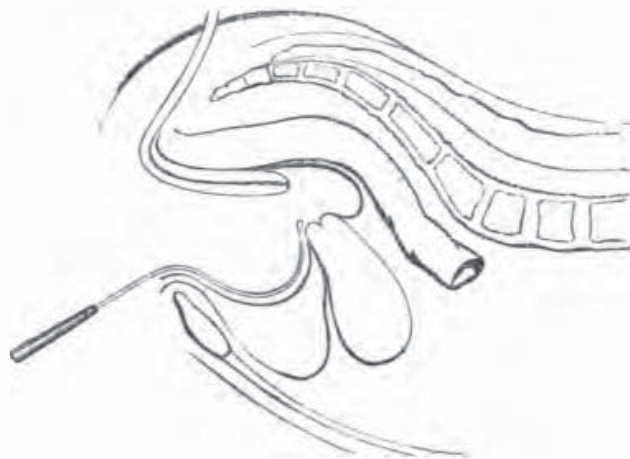


of the sound is hidden from view by the lateral folds of the vagina, which fall over it and meet in the middle line, showing us exactly where the tissue is to be removed for the purpose of uniting the parts that thus so naturally and easily come together. With the parts thus held, it is very easy to denude

two surfaces a third of an inch wide or more, extending seemingly almost in parallel lines from the neck of the bladder up on each side of the cervix uteri. To make the transverse lines of denudation at the upper ends of these two arms of the *V*, we remove the curved sound and pull the cervix downwards with a small tenaculum. We must be careful not to make the arms of the *V* too divergent, and at the same time we must avoid running them too closely together. They should, when united by sutures, relieve the cystocele without putting the parts too much on the stretch. The sutures are, of course, to be passed transversely, beginning below, as represented in fig. 4. The sound is to be retained, pushing the uterus backwards till we come to pass those near the cervix uteri. These should be made to embrace all the denuded tissue, *c*, *d*, fig. 6, excluding the undenuded portion *e*. I think it very important to leave a drain here, as before said, for the discharge of the normal secretions of the pouch *f*.

Fig. 8 represents the speculum in position, and the curved

Fig. 8.



sound pushing back the cervix and depressing the anterior wall of the vagina.

Sometimes, as in cases complicated with rectocele, it is necessary to narrow the posterior wall of the vagina, as well as the anterior. If so, I prefer to make two operations, allowing a period of six or eight weeks to intervene between them.

It is not my intention to draw a parallel between this and the perineal operation for procidentia. I only wish to add another resource to our means of permanent cure in this distressing affection. So far, then, as mere surgical resources are concerned, we have three processes from which to choose; always, of course, adapting this choice to the peculiar exigences of the case.

1st. Amputation of the cervix, as recommended by Huguier, when its infra-vaginal portion is too long. I have often seen procidentia cured by this alone.

2nd. The perineal operation, as performed by Mr. Baker Brown, Dr. Savage, and others; and

3rd. The operation of narrowing the vagina by the trowel- or triangular-shaped denudation on its anterior wall, as herein illustrated.

Mr. NUNN stated that he had, on several occasions, operated for prolapsus uteri after the plan recommended by Mr. Baker Brown. In most of the cases a partial rupture of the perinæum had existed. In them the result of the operation was satisfactory on the whole; but he considered it very advisable to provide the patient with a suitable bandage, so as to help the new perinæum as much as possible, since there was, undoubtedly, a tendency to expansion. Mr. Nunn adduced one example in which a small aperture was left between the new perinæum and the sphincter ani, that had, after a year or two, dilated to the size of a florin. Where no rupture of the perinæum existed, as in younger women, who had never borne children, Mr. Brown's operation had failed. Mr. Nunn stated that he had operated on patients even of nearly seventy years of age with advantage. He also stated that he had himself, and had also seen Mr. Brown on many occasions, practised a proceeding *somewhat* resembling that described by Dr. Sims, namely, the removal of a V-shaped portion of the mucous membrane of the vagina reaching from the fourchette to within an inch or so of the cervix—the difference being that this removal was made from the posterior instead of the anterior or vesical wall of the vagina.

Mr. SPENCER WELLS said that the operation suggested by Dr. Marshall Hall had been performed many years ago in London. He (Mr. Wells) had seen two ladies upon whom it had been performed by the late Dr. Hemming, of Kentish Town. In one, circular strips of mucous membrane had been removed all round

the vagina by the knife, in the other by the cautery. No sutures had been used, the idea being to obtain contracted cicatrices. This was obtained, and the uterus was well kept up. One lady had not had children since, and was well content; but the other became pregnant, and was attended by Dr. Rigby. During the labour the head of the child carried the cicatricial rings before it, and literally stripped the vagina of all its mucous membrane. It did not open either bladder or rectum, but the recovery was very protracted. Mr. Wells wished to know whether any such result had been observed in patients who had borne children after submitting to the operation described by Dr. Sims.

Dr. RASCH referred to a number of cases in which he had operated for prolapse or procidentia of the womb. In all his cases there was rupture of the perinæum present, and in all he adopted Mr. Baker Brown's operation, only in two slighter cases omitting the quill sutures. All did well. A very bad case of complete procidentia of many years' standing was much benefited by the operation, and continued so two years after, the os uteri, however, resting on the new perinæum, though not protruding. Dr. Rasch certainly would follow Dr. Sims' very ingenious suggestions, especially where there is no rupture of the perinæum, as in all cases he had operated upon the protruding anterior wall of the vagina was much less relieved than the posterior.

Mr. I. B. BROWN, jun., said that the cases of prolapsus uteri on which Dr. Rasch had operated were caused by the rupture of the perinæum, and it seemed but rational, when this was the cause of the prolapsus, to perform the so-called "perineal operation." It was, however, undoubtedly true that, in what might be termed idiopathic prolapsus, cystocele was a very prominent accompaniment, and in such instances he could not conceive anything better than the ingenious operation of Dr. Marion Sims. He would, however, remind Dr. Sims that Mr. Baker Brown, recognising this fact, did, in cases where cystocele was present, diminish the vaginal wall of the bladder, not to the same extent, but in a manner very similar to that of Dr. Sims, namely, by paring the mucous membrane, and bringing the raw edges together by silver sutures.

Dr. AVELING ventured to suggest to Dr. J. Marion Sims whether it would not be advantageous to have the opening for allowing the secretions to escape from the pouch at the lower angle of the triangular space operated on. This would be a more dependent position for the outlet. There would also be another advantage in having it so placed. The mucous membrane immediately over the urethra would remain undisturbed, and there would be no danger when passing the sutures in wounding or closing that canal.

Dr. WYNN WILLIAMS remarked that, as regards the success of

the operation performed by Mr. Baker Brown, he had met with several cases that had been operated upon by Mr. Brown, and he must say that the patients appeared to him to have been but little benefited by the operation. Indeed, in one case, where the woman afterwards became pregnant, almost all traces of the operation had disappeared. He had long been of opinion that when the anterior portion of the mucous membrane of the vagina protrudes, which, as the author of the paper states, is usually the case, the tension should be brought to bear on the upper part of the vaginal mucous membrane, and this, he believed, was best attained, in ordinary cases, by wearing a pessary like the one he held in his hand, which acts by making tense the mucous membrane reflected from the vagina to the uterus, the uterus being suspended between the blades of the pessary. Dr. Williams could not remember who was the inventor, but it was improved by the late Dr. James Reid. It is not Zwanck's, having been invented long before his. It has no hinge, but is kept open by its own spring.

Dr. WILKINS, of William's Town, Australia, stated that he had operated on two cases of procidentia uteri, following closely the method of Mr. Baker Brown as described in his book; permanent success had followed the operation, even though one of the cases had been of twelve years' standing. Dr. Tracey, of Melbourne, had also operated on several cases, and he believed with similar results.

Mr. CHAMBERS said he felt that the Fellows of the Society were much indebted to Dr. Sims for his valuable contribution to female surgery; but he submitted that even this operation was inadequate to meet the requirements of all the cases of complete prolapsus uteri which come under the notice of the surgeon from time to time. Thus, this, which may now be called the anterior operation, only takes rank with that which may properly be called the posterior operation, or Mr. Baker Brown's. Mr. Brown has never asserted that his operation is successful in every case of prolapsus uteri. On the contrary, he has for years past combined the two operations in cases necessitating such a procedure, though he (Mr. Chambers) was bound to say that the anterior operation, as performed by Mr. Brown, was a very simple one when compared with Dr. Sims'. He had had two very bad cases of this kind under his care within the last twelve months. One case was of three years' standing. This lady had not been able to leave her house for more than two years. He performed Mr. Brown's operation in November, 1864, and the patient is now in excellent health, having had no signs of a relapse. The other case was that of a poor woman who had suffered from a complete form of the disease for "over two years." Mr. Brown's operation was performed in this case, and for six months she has discharged the duties of her station with perfect ease and comfort. This patient came to the out-

patients' room a month ago, and the parts appeared as perfect as when the operation was first performed. There are two important reasons why the posterior operation so often fails in the hands of some operators—first, the operation itself is *in many cases* very imperfectly performed; and second, the patient is permitted to get up and walk about long before the united surfaces have had time to become perfectly consolidated, or the enlarged uterus to become reduced to anything like its normal size and weight. Cases of this kind ought not to be permitted to leave their bed for eight or ten weeks at least, if the cure is to be permanent.

The PRESIDENT said he had asked for the experience of Fellows on the result of Mr. B. Brown's perineal operation, because, if this were found to fail, the argument in favour of Dr. Sims' operation was much strengthened. He had himself performed Mr. Brown's operation several times. He had found prolapsus return in spite of the provision of a good perinæum. Further, he had known complete prolapsus take place in virgins; in one case especially, that of a girl aged sixteen, prolapsus was caused by epileptic fits, the vulva and perinæum being quite normal. Again, he had repeatedly seen the uterus remain *in situ* notwithstanding large perineal laceration. It was clear to him, therefore, that defective perinæum was not the cause of prolapse, and that operations for restoring the perinæum or contracting the vagina posteriorly could not be expected to cure it. It seemed to him that Mr. Brown's operation was performed in the wrong place. It had no effect in providing support where it was wanted, namely, anteriorly, at the connection of the cervix uteri with the base of the bladder. This object seemed to be perfectly accomplished by the admirably reasoned-out and ingenious operation of Dr. Sims. Dr. Barnes briefly described his view of the etiology of the hypertrophic elongation of the cervix. It began with congestion, inflammation, and partial eversion of the lower margin of the cervix. The outer or vaginal surface of the vaginal portion was the more fixed, whilst the inner aspect of the canal more easily bulged outwards. Then the products of congestion became organized in the tissues, the fluid elements being absorbed. This process continually going on—eversion or growing out of the rugæ of the cervical canal—extension and hypertrophy went on. A demonstration of this kind was obtained by passing the uterine sound up to the fundus, and then gently pressing upwards, so as to push the prolapsed uterus back towards the vagina. The last-formed everted portion of the canal then disappeared under a process of reinversion. This showed how the abnormality might be prevented if the original inflammation were cured in the early stage, and if the uterus were properly supported in its normal position.

Dr. SIMS, in reply to Dr. Aveling, said he left the undenuded portion of mucous membrane near the cervix uteri, because this

was the most dependent part when the patient was lying down. In reply to other speakers, he said that no one method of operating could be applicable under all circumstances to all cases. If there was a lacerated perinæum it was proper to restore it. If there was elongation of the infra-vaginal portion of the cervix, then the proper operation was amputation of the cervix, and this would probably be all that was necessary in such cases. His friend Dr. Eastlake had shown him a case of procidentia two or three days' ago, where it depended entirely upon hypertrophic elongation of the lower segment of the cervix, which projected at least two inches below the insertion of the vagina. This patient had been the rounds of many of the hospitals in London, and nothing had been done for her. The perineal operation and his own method were each equally powerless to remedy such a case. Amputation here was the only resource. He had the pleasure of operating on a patient of Dr. Henry Bennet's, a few months ago, where the procidentia depended upon hypertrophic elongation of the cervix. The operation of amputation alone cured the case. In the majority of cases of procidentia—in all those where a vagino-cystocele formed the first stage of descent—he was satisfied that the operation he had described, viz., that of narrowing the vagina by forming a longitudinal fold of its tissue on the anterior surface, reaching from the neck of the bladder to the neck of the womb, would be one of the safest, simplest, and best. As to mechanical means for such cases, he had seen the instruments fail which Dr. Williams had shown us. He had seen cases in which Hodge's lever, Meigs's ring, globes, discs, and air-balls, were all useless. In some cases Zwanck's pessary would answer; but no instrument could be compared with his simple operation for a radical and permanent cure. Besides this, there were many who could not bear any mechanical apparatus. In old women the vagina was often so delicate and tender that none of the ordinary forms of pessaries could be borne. In such cases, if the patient would not submit to the operation, and could not wear an instrument, there was still one thing left to palliate her condition, and that was she could wear a tampon of cotton, the size of an English walnut. It should be moistened with glycerine, and introduced every morning, to be removed at night. He thanked his friend Mr. Spencer Wells for the information in regard to the operation of Marshall Hall as performed by Dr. Hemming. He was not surprised to hear that cicatricial rings, made around the vagina by the actual cautery, had sloughed away during labour. Marshall Hall's idea of narrowing the vagina was good, but his method of doing it was bad. He gave to Marshall Hall the credit of suggesting it, but claimed for himself that of effecting it properly. To a question, he said his friend Dr. Emmet, of New York, had seen a labour after this operation without injury or accident of any sort.