THE

MANUAL TREATMENT

OF

DISEASES OF WOMEN

BY

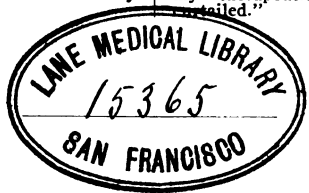
GUSTAF NORSTRÖM, M. D.,

OF

THE FACULTY OF STOCKHOLM.

The deceased DR. VULLIET, Professor of Obstetrics and Gynecology at the University of Geneva, states in a pamphlet on gynecological massage: "I have cured by this method many patients, who had wandered from one gynecologist to another, and whom I also had previously treated without success by other methods."

DR. SCHAUTA, Professor of Obstetrics and Gynecology at the University of Vienna, states in his Lehrbuch der gesammten Gynäkologie: "Massage has been an invaluable therapeutic measure in the many years that I have employed it. Without it I should feel my therapeutic resources greatly curtailed."



NEW YORK:

1903.

PREFACE.

The following monograph is a supplement to the works which I published in Paris, in 1889 and 1892, on the application of massage to gynecology. It is based on the observations which I have gathered in my experience extending over more than twenty-five years.

My first modest work, published in 1876, was really the first scientific treatise on this subject. If this one was wanting in merit, it at least possessed novelty and was an attempt to popularize this subject.

The majority of cases which follow have been gathered during the service of Dr. Péan at the St. Louis Hospital during 1876, 1877, 1889, 1890 and 1891. He was kind enough to refer to me a number of patients suffering from chronic uterine and peri-uterine inflammations, whom he did not wish to treat surgically, and in whom a great many means employed by modern gynecologists had been of no avail. He also permitted me, during the latter part of my service at the hospital, to lecture on gynecology, and especially on gynecological massage. I am pleased to again be able to thank this eminent surgeon, for no one was more sincerely interested in these new methods and no one was more frank in favoring their adoption, as he considered them of great value. In the majority of the patients douches,

pessaries, general treatment, cauterization and curettage had been employed. None of these means had been of lasting benefit. The condition of the patients was carefully noted at the commencement of massage, and this was the only treatment employed. At the end of the course of treatment their condition was again noted; consequently if the patients were cured or improved, this circumstance could only be attributed to the treatment employed.

In order to ascertain whether this improvement was lasting I had the patients return to the clinic at intervals of a half to two years. Unfortunately but a small number returned, so that I was unable to follow them up as I should have desired. Some of the patients had come to be treated from the country, and, not being in affluent circumstances, it was scarcely advisable to entail an expensive journey upon them for such a trifling matter. Others who lived in Paris, although they had faithfully promised to return, never put in an appearance. However, in spite of this, later examinations were made in a sufficiently large number, as may be gathered from my cases, especially in those who suffered from para- and peri-metritis alone, or complicated with uterine displacements,—as versions or flexions.

In all these cases I followed Brandt's method. However, I did not think it indispensable to follow his mode of procedure in every detail. I have omitted certain manipulations which to me appeared superfluous. My results have been very gratifying, and I have not a single regret in having adopted this modified procedure.

I believe that through my publications[1], as well as my papers read before the Paris Academy of Medicine, some twenty odd years ago, I helped to popularize a method which, in spite of much opposition, finally succeeded in gaining proper recognition. I see abundant proof of this in the adoption of this method of treatment by a large number of physicians. Instead of listening to theoretical objections, they have ascertained the real value of the method by its practical employment.

Having used this method for more than thirty years, I have tried to be as conservative and practical as possible, so as not to be carried away with enthusiasm and give it more credit than it really deserves. This would only ultimately retard its adoption.

New York, May 15, 1902.

[1] "Massage de l'Utérus, Paris, 1889," and "Massage dans les Affections du Voisinage de l'Utérus et de ses Annexes," Paris, 1892.

CONTENTS.

CHAPTER V.

Parenchymatous Metritis and Its Consequences.—Anatomy of the Uterus.—Predominance of Venous over Arterial Supply.—Nerve Endings.—Influence of Parenchymatous Inflammation Upon the Mucous Membrane.—Venous and Lymphatic Stasis.—Uterine Catarrh.—Possibility of Impregnation?—Acquired Sterility.—Influence of Massage.

CHAPTER VI.

Parenchymatous Metritis and Its Consequences.—Interstitial Exudation.—Venous Stasis.—Fatty Degeneration of the Muscle.—Alteration and Organization of the Exudate.—Uterine Sclerosis.—Alterations in Shape and Changes in Position.

CHAPTER VII.

Mechanism of Dysmenorrhoea.

Congestive and Mechanical Dysmenorrhœa.—Infrequency of the Latter.—Phenomena Accompanying Dysmenorrhœa.—The Effects of Massage on Chronic Metritis.

CHAPTER VIII.

Massage in Different Uterine Affections.—Subinvolution.—Prolapse.—Fibroids.

CHAPTER IX.

Operative Manual in the Affections of the Neighborhood.

CHAPTER X.

Parametritis.

CHAPTER I.

Interpretation of Brandt's Method.—Its First Use at Stockholm.—Its Use at Paris.—Clinic of Dr. Pacquelin.—In the Service of Dr. Pean, at the Hospital St. Louis.—First Publications.—Their Results.

In the month of September, 1869, I made a tour of the most important scientific centres of Europe with the avowed purpose of studying gynecology, intending to take up this specialty on my return to Sweden. The historic events of 1870 compelled me to interrupt my studies. I resumed them after the campaign of Sédan, in which I participated as surgeon of the 6th French ambulance corps of the Society of First Aid to the Injured; I visited the principal hospitals in Berlin, Paris, Vienna, London and Dublin. Toward the end of 1871, persuaded that I had acquired sufficient experience to begin practice, I returned to Stockholm. At the end of a few months I was painfully cognizant that, in spite of the numerous means then at the disposal of gynecologists, the majority of uterine affections and its adnexa resisted the best conducted treatment, and that most of the methods were simply palliative and powerless to cure. One might consider himself indeed fortunate if, having persevered, a partial cure or even a temporary amelioration was obtained. At that time, it only remained for the

physician to console his patients on their incurability, a thankless part for the physician to assume. The cases which I was going to treat were not utterly hopeless and did not arise from profound alterations in structure; they were neither carcinomatous nor sarcomatous in nature, but had baffled the most radical measures. Upon most chronic inflammations we looked as being susceptible of only a partial cure, and when they did get well it was only through the *vis medicatrix naturæ*.

After I had been but a short time in Stockholm I was surprised to learn that some cases which had been under treatment for years by eminent specialists, and others which I saw and which belonged to the class of cases I am writing about, were wholly cured by empirics—as the elder Thure Brandt, without any medical knowledge whatever. At first I challenged the marvellous cures which were reported. In the North, as elsewhere, one is rather sceptical to believe in measures which are rejected by physicians. But I had had the opportunity to personally see, examine and even treat some of the cases before they had been treated by Brandt. I had the histories of these cases, with my diagnoses; and their prognoses were unfavorable. The results had been excellent, so that I was no longer sceptical. The method of my fellow countryman had not been described in books, but was certain to be lasting, for it had been successful in cases where others had failed; it was neither the first nor the last example of therapeutic discoveries having been made by chance. Empirics often have a boldness and perseverance not possessed by scientific men,

who are accustomed to feel their way cautiously, always ready to deny what is not explained by reason. For example, a professor or physician at the hospital would have hesitated to employ water as Priessnitz did. The latter was a simple peasant, without medical knowledge, who thought he had discovered a panacea, treating everything by affusions and sprays, made converts, and may be considered the father of hydrotherapy. Brandt did not even employ water,—manipulation was the basis of his method, which was a variety of massage as applied to the pelvic organs. As he employed it in 1871, many of the procedures were useless. I have never literally followed his manipulations, but I was forced to recognize his principle as rational. It was just the proper idea to apply massage to soft tissues which were subject to persistent passive congestion and chronic inflammation. After what I knew and had already seen, I determined to use the method, modified to as simple a manipulation as possible. The results justified my boldness. I cured those inflammatory conditions of which I had formerly despaired. I soon formulated the proper indications, and since then I have modified my ideas but little. In 1875 I returned to Paris, persuaded that there nothing was yet known of Brandt's cures, about which very little of importance had been written.

I was convinced that his method was excellent and hoped to have great success. From the time of my arrival I had the good fortune of meeting Drs. Péan and Pacquelin. The former offered me his ward at the Hôpital St. Louis, the latter his clinic in the Rue de Provence. This

was a fortunate opportunity for me, and just what I had desired, to employ the method fully and under the supervision of eminent specialists who entertained no preconceived ideas. I thought this to be the proper way in which to popularize it and, above all, have its true value recognized and appreciated by medical men. It was at the latter clinic that I treated my first patients, and I have gathered many cases which have aided me in preparing the paper read before the Academy of Medicine, January 18, 1876.

I obtained the same good results at Paris as at Stockholm. My statistics were fairly satisfactory in demonstrating that if the facts I reported were real, uterine massage was useful; that the method had not yielded all that it was capable of yielding; that it was worthy of engaging the attention of those interested in gynecology. I was a trifle discouraged by the reception given to my efforts; but this is the fate of all who attempt to introduce new ideas, for I was satisfied that I was right in taking this stand. It is imagined that massage of the uterus is inefficacious; let us take, for instance, a woman suffering from metritis (endometritis), even inveterate, with continual discharge, flexions and reflex symptoms, examine her in such a way that no doubt exists as to the disease. I will treat her for two months, and you can then judge of her condition. This method of demonstration, if employed with success, is irrefutable. I have made this proposition many times. No one responded to my proposition; nobody listened to me; I encountered sceptical ridicule which almost stranded

me. It was a bad time to speak about uterine massage. In the work which I have published on this subject I related how massage, French in origin, had fallen into oblivion. To-day it has been revived in France, but in 1875 many physicians who had hardly heard of it considered it the method of a bone-setter, uncertain and painful, which one might advise, but had better let alone. It appeared hardly proper to apply massage to the pelvic organs when it was hardly used in joint affections. In spite of all these disappointments, my conviction remained firm. I had sufficient experience to know the value of the method. All the physicians in the world could not convince me that my opinions were false. But the feeling of opposition seemed like a mortal blow to one who so chose to regard it. How could any one speak of uterine massage after that? Those who were best acquainted with it, who had been thoroughly convinced of its utility, practised it in silence, without calling or writing about it under this name. Since 1876 I have constantly employed it and have cured bad cases of chronic metritis with structural changes, complicated or not with displacements of the organ, as well as in cases in which there were affections of the appendages. I have accomplished this and made life bearable for women who for many years had employed every so-called infallible douche, every pessary devised for the purpose, in whom cauterization of the cervix and curettage of the uterus, etc., had been resorted to.

I have collected notes on this subject, but have hesitated to publish them, as I have previously encoun-

tered so much opposition. I shall explain why I cast aside my reserve.

CHAPTER II.

Employment of Massage in Gynecology.—In Sweden, Norway, Finland, Denmark, America, Germany, Austria, England, Russia, France, etc.—By Whom Recommended.—Difficulties Which Are Still Urged Against Gynecological Massage.—Different Names of the Method.

The circumstances which compelled me to be so guarded in adopting this procedure were fortunately of short duration. Even in Stockholm, Brandt found for the support of his method, or at least the principle of it, a great scientific ally in Dr. Sahlin, who was at that time docent, but now is adjunct professor of obstetrics and gynecology at the University of Stockholm. This eminent physician employed gynecological massage for many years, and his results were so encouraging that he would not dream of abandoning it. I am very glad to learn that my esteemed colleague, Dr. Netzel, professor of gynecology at the University of Stockholm, who had the opportunity of studying the treatment at the very spot where it originated, and who was formerly an opponent of gynecological massage, has of late years become a strong advocate of it. Dr. Netzel, who does not practise massage himself, sends all cases requiring massage to a colleague who makes a specialty of the subject. The

eminent gynecologist, Dr. Josephson, of Stockholm, a few years ago published a pamphlet on this very subject in which he appears as a fervent admirer of gynecological massage.

Dr. Lindfors, professor of obstetrics and gynecology at the University of Upsala, who has also for several years employed pelvic massage in his clinic, says in an article published in the Monatschrift für Geburtshilfe und Gynäcologie (Bd. IV. H. I.), under the title "*Die Methode Thure Brandt und die Schwedischen Aerzte*": It is certain that gynecological therapy has discovered a new aid in massage, which has also contributed to exactness in diagnosis. No gynecologists, and Swedish physicians least of all, will ever forget to bestow thanks upon the noble and unselfish Brandt for what he has accomplished.

At Christiania, Dr. Nissen practised the method for several years with equal success; at Copenhagen, Professor Howitz, one of the most justly esteemed gynecologists of the North, who died last year, extensively employed this method in his clinic. At Helsingfors, Professor George Asp has used it since 1874. His results were so satisfactory that in 1878, when this method was still looked upon with suspicion, he published statistics with accompanying deductions on many interesting cases. "Considering these facts," he said in conclusion, "I can say that this method judiciously applied and with proper precautions merits more consideration than any other having the same end in view. I did not intend, in publishing this pamphlet, to enter into any controversy

with my opponents, but simply to give my results obtained in my four years' experience."[1]

In America, gynecological massage has had as one of its first advocates the well-known gynecologist Dr. Reeves Jackson. After having enumerated a certain number of affections in which it seemed to him to be indicated, he voiced the same opinion as Dr. Asp and he looked upon it as a good remedy, the efficacy of which could not reasonably be doubted[2].

Besides this communication, as far as I know, there appeared only a few articles deserving mention in the medical journals, those of Drs. Taylor, Findlay, Montgomery, Rumpf, Nordhoff, Jung, Walter, and particularly Vineberg and Wetterschutte, of Chicago, who translated Ziegenspeck's work on gynecological massage. My distinguished countryman, Dr. Hogner, of Boston, who, in addition to his general practice, devotes a portion of his time to gynecological massage, read some years ago a comprehensive and scientific paper favoring the method before the Boston Medical Society. Up to this time there existed but vague ideas about this application of massage.

In Germany this method is employed in Professor Schultze's clinic at Jena. He and Schauta are the first regular physicians who introduced and taught this important branch of therapeutics at their clinics. Thanks are due to Schultze for the important position

---

[1] Om Lifmodermassage. Nord. Med. Arkiv., Bd. x. No. 22, 1878.

[2] Uterine massage as a means of treating certain forms of enlargements of the womb. Gynecological Transactions, Vol. V.

now held by this method of treatment in modern gynecology, and while formerly ignored, some space is now devoted to pelvic massage in every gynecological work of importance.

At Greifswald, Professor von Preuschen has employed it a great deal. Professor Olshausen likewise practises it in his clinic at Berlin. He has lately published his views on the subject in an article which appeared in Centralblatt für Gynäkologie, January 19, 1901. I am pleased to note that from formerly having been an opponent of the method, he has now become an advocate of it, at least when employed in the treatment of periuterine affections. Dr. Prochownitz in Hamburg, too, published his remarkable work on the method in 1891.[1] At Munich, Dr. Ziegenspeck is chief of a clinic where a large number of physicians are annually instructed in this method. In Vienna, the late Dr. Bandl employed it; Dr. Profanter in a well-written paper has collected sixteen cases of chronic periuterine cellulitis which were cured by massage[2]. This subject was thoroughly discussed at a meeting of one of the Vienna medical societies on March 29, 1887, as a result of Dr. Fellner's paper.

I was greatly pleased to read that Professor Schauta, in his book (Lehrbuch der gesammten Gynäkologie, 1896) repeatedly endorses gynecological massage. He has practised it for many years at Vienna, where he occupies the chair of gynecology and is recognized as one of the foremost gynecologists of Europe, as the many

[1]Die Massage in der Frauenheilkunde.

[2]Die Massage in der Gynäkologie, Wien, 1887.

American physicians know who go to Vienna to complete their medical studies. In the above work he states as follows: "Massage has been an invaluable therapeutic measure in the many years that I have employed it, and without it I should feel my therapeutic resources greatly curtailed."

In Russia this procedure has found a strong advocate in Dr. Ott, who spoke of it in the very highest terms at the third Medical Congress of Russian physicians[1]. At the same congress Dr. Semianikov reported the favorable results he had obtained in its use at Professor Slavianski's clinic in St. Petersburg. The high position gynecological massage at present occupies in Russia is indicated in a letter recently received from my friend Professor Zabludowski, of Berlin, who informs me that it is taught in three of the leading medical schools of St. Petersburg, viz.: at the Military Medical School, the Clinical Institute of the Grand-Duchess Helene Pawlowno, which is a postgraduate school, and at the Women's Medical College.

Professor Vulliet, whose untimely and much regretted death prevented him from presiding at the Gynecological and Obstetrical Congress of 1895 at Geneva, has stated in his pamphlet on gynecological massage that he has cured by this method many patients who had wandered from one gynecologist to another and whom he also had previously treated without success by other methods.

---

[1]Massaj i gimnastike kak lietchebnyu sposob pri boliezniak jenskoi bolovoisphery. Vratch, 1889, No. 6.

In France, gynecological massage met with a great deal of opposition, perhaps more than in any other country; but, in spite of this, it has nevertheless gained ground, and in the end triumphed. I have seen proof of this in the constantly increasing number of gynecologists who are employing it. I shall, among others, mention the following: Leblond, Rosenblith, Goldspiegel and especially Stapfer and Auvard. As a proof of the high esteem in which gynecological massage now is held in France by eminent obstetricians and gynecologists I shall quote what Dr. Pinard, professor of obstetrics at the University of Paris, says, among other things, in his preface to Dr. Stapfer's work, "Traité de Kinesotherapie Gynécologique": "When the reader has seen the results of the experiments performed by Dr. Stapfer and his pupils they will understand why I have been so insistent on a proper physiological understanding of the subject, and, if I am not mistaken, the importance of these discoveries in physiology will even be more marked. In regard to the value of this new therapeutic measure, I can say that I am convinced because 'I have seen.' For the last five years I have entrusted a portion of my gynecological work at the Clinic Beaudelocque to my colleague, Stapfer, and I have seen and felt the changes which took place. I can further attest to the good results obtained, and I may add that, if by chance any remain incredulous after reading this book, I invite them to come and investigate for themselves. My clinic is open to them. Casual visitors who attend the clinic out of curiosity will remark the simplicity of the procedure.

Those who persevere and are really interested will see the results."

How voluminous the literature of gynecological massage is can readily be seen by glancing at the bibliography at the end of this book.

The many cases, investigations and papers on this subject fully demonstrate its value. Competent physicians of different countries would not give it their approbation on account of its supposed inconvenience or rather its alleged indelicacy. If it has strong advocates it must have advantages. Apropos of this, you might slightly modify the Hippocratic definition of the healing art, and say, "It often cures and always relieves." The objections formerly urged against it are insufficient to cause its rejection. Very often a method of treatment is introduced and adopted too soon as a fad. Does this apply to massage? I think not. Do they object to the operative manual? It is proper and simple. The body of the uterus is steadied by the index and middle fingers of the left hand, introduced in the vagina, while the right grasps the fundus through the abdominal wall. No matter what book on gynecology you read you see this procedure described and recommended for gynecological examination.

Gallard, for instance, in his well known textbook on gynecology, says: "If you wish to make your examination as thorough as possible you must practise the vaginal touch supplemented by palpation through the abdomen.

"While the fingers, introduced in the vagina, or one finger in the vagina and the other in the rectum, are pushing the uterus and its appendages from below upward, the other hand, steadying the anterior abdominal wall, gently presses the latter downward toward the pelvic cavity as far as possible, until the body of uterus is felt, if the organ is in a normal condition."[1]

Now, I ask, is it wrong to employ a measure for a therapeutic use which is readily used to make a diagnosis and which one is obliged to practise, too, during the treatment from time to time, to ascertain whether any progress is made? Furthermore, it is easy to speak of indelicacy. For it is only a little over two-score years ago that the use of the vaginal speculum caused a storm of objections in England. These are now completely overcome, and nowhere has gynecology made greater progress than in that country. Auscultation had been called improper; this objection was principally made by the better class of people, but it nevertheless made its way. The treatment we are discussing is more or less painful, and the pain would dispel any erotic feeling which the manipulation might cause; and on account of the pain, women are less disposed to submit to this treatment in preference to any other, in spite of its simplicity. It is quite astonishing to see how patients often improve under massage in a very short time, and how some who come suffering greatly in walking and stooping over, on account of pain and weakness, will quickly improve and are soon able to go about painlessly,

[1] Leçons cliniques sur les maladies des femmes, Paris, 1879, pp. 231. 232.

resuming their household duties. A treatment which would give rise to erotic sensations, as above supposed, would certainly exercise a debilitating influence and cause opposite effects.

Thure Brandt practised the method which bears his name for thirty-five years, sometimes treating fifty patients a day, and numbering among his clientèle all classes of society, among them several distinguished persons. His patients came to him not only from Scandinavian but also from other European countries, and even from the United States, so world wide was his reputation.

Furthermore he lived at a time when he could expect no sympathy from medical men. I am glad to say, however, this attitude on the part of the physicians in his native country changed as soon as Swedish physicians became convinced of the efficacy of massage, for I think the chief objection to his method was that he was not a medical man. Against the method itself not a single objection could be urged. It is hard to imagine that Scandinavian women, who are as modest and respectable as those of any other nationality, would not object to a procedure which others would repel with disgust and indignation as immodest.

Prochownik, in his work, casually refers to the inconvenience, as, he says, he only heard of it through my French treatise on the subject.

My distinguished countryman, Dr. Josephson, in his pamphlet on pelvic massage, does not allude to the objections of massage, assuming that in Sweden and in Scan-

dinavian countries in general the matter is sufficiently well known and recognized. For my part, I believe that hardly a Swedish physician of the new school, and not prejudiced against pelvic massage, can be found who sees in this method any objection from a moral point of view, and who would not attribute to it great therapeutic value. During the two or three years which I spent at the St. Louis Hôpital, in Paris, in Dr. Péan's clinic for surgical and women's diseases, I practised the method on cases for which massage was more appropriate than surgical intervention, and it seemed to me that no one was able to raise any objections on the score of decency in pelvic massage.

There were about ten or twelve women treated daily, and sometimes even more, and the treatment was carried out in the presence of not only the chief surgeon himself (Dr. Péan), but also the internes and externes of the hospital, as well as a large number of French and foreign physicians who accompanied him on his rounds. Toward the end of my stay at the hospital, while making rounds one day, Dr. Péan, after having seen the large number of patients which had come under his observation in the two years and a half of my service, and which he himself had examined, in referring to massage as applied to the pelvic organs, said that, if this method was to be condemned on account of its immorality, it would be equally improper to question or examine *any* woman with regard to the functions of these organs; that it was ridiculous to attribute to this procedure, if properly performed, any erotic sensations; and there was no valid reason why

any prejudice against the method should exist. Dr. Pacquelin, whose successor I had the honor and pleasure of being at the clinic which bears his name and where I had charge of the gynecological division, had the same opinion of pelvic massage. I always practised it with great enthusiasm, and frequently Dr. Pacquelin would come in to see the results for himself, and many times told me how deeply he was interested and how his most sanguine expectations were realized. He could not understand how French physicians could seriously object to the immorality of this new method of treatment. In order to convince them of the falsity of their preconceived notions, he invited them to visit his clinic. I had the pleasure of seeing many come, among them some eminent physicians, who on departing confessed that they had been completely mistaken and had looked upon gynecological massage altogether too lightly; and what they had seen was altogether different from what they had imagined. I also saw many who came solely out of curiosity without any definite ideas about gynecological massage. These were not slow to realize that the objections were absolutely groundless. Pr. Pinard, who, as I have above mentioned, entrusted a part of his service at the Baudelocque Clinic to Dr. Stapfer, said, in the preface to his book, that he saw no reason to object to this treatment during all the years he had practised it since the publication of his treatise on the subject. It seemed quite clear to me that if this had been the case, Dr. Pinard would soon have lost his high standing. On the Continent I have spoken to

several eminent gynecologists about this method, and I have noticed that the very ones who had never tried gynecological massage, only having heard of it, were the ones who spoke ill of it, particularly from a moral point of view, while those who had tried to practise it were well pleased with it in any way. I could adduce more arguments to prove that gynecological massage is not at all objectionable, but this would be useless, as there always exist prejudiced persons with whom arguments are of no avail. Do contra-indications to the treatment exist, at any time? Perhaps, in some nervous or psychical affections, but many methods of treatment are daily employed by physicians, especially in the treatment of diseases of women, which can provoke the same erotic sensations and which are likewise open to the same objections. Is this a sufficient reason for discarding a therapeutic measure as immoral? I admit that the method can have some disadvantages, as many others have which are in daily use.

I have perhaps dwelt too long on the alleged immorality of gynecological massage. I would have preferred not to have touched upon the matter at all, since it is indelicate to speak of it, but as this very thing was the principal objection raised against its general adoption in the United States, I was compelled to fully discuss it.

The recoveries brought about by a therapeutic measure are the best arguments in its favor. Gynecologists who have seen the results of pelvic massage have become strong advocates and even enthusiasts. Some objections, however, have not been overcome.

Why, then, is not such a useful method more popular —a method which often cures when others have failed; for the application of which no complicated armamentarium is required; which is not fraught with any danger when applied by a competent physician; whose results are so soon evident that patients often show decided improvement at the end of a fortnight? I have asked this again and again.

It is difficult to overcome old prejudices. I have often spoken to intelligent and progressive physicians, who kindly took up new ideas which they thought were applicable for practical use. I was surprised to learn that they did not think well of gynecological massage. They entertained erroneous ideas about the operative manual, and knew nothing of its results. I had great difficulty in explaining it to them. I met only some few who were quite willing to take up the experiments with me, that is, examine a patient who was affected, for instance, with peri- or para-metritic exudates and verifying the changes which had taken place after three to four weeks' treatment. I do not believe any demonstration more rational and just.

All who have practised or seen pelvic massage practised in the affections I have mentioned are unanimous in admitting that patients are subject to no risks, provided the method is properly applied.

It is strange that such a method should only be employed in Scandinavian countries, on the advice of physicians; it is indeed strange that conditions of treatment should be more favorable there. Yet the

sooner one begins to treat these cases, the quicker the results; as it is easier, for instance, to cause the absorption of recent exudates, imperfectly organized, than old and thickened adhesions which have been treated in vain by other methods. Indeed, the patient's interest demands as early treatment as possible, to prevent months, perhaps years, of suffering.

I have also had occasion to treat women belonging to the better class. But the greatest number of the cases, which I will discuss at greater length later, belonged to the working classes, and came to the above mentioned clinics of their own accord. Many of them came there because some of their friends who had been sick a long time were able to resume their work after having been treated by me for a month or two by massage. At times improvement took place very soon, but this has sometimes its disadvantages; if the pains are markedly diminished and the discharge and flow are almost gone, they are so satisfied that they stop the treatment. It is well to tell them that these early improvements are not sufficient, and that the diseased organ has only been slightly benefited. These anatomical-pathological explanations influence them but little; they suffer less than before, and are so much better that nature, they say, will do the rest. You cannot rely much on their cooperation. As long as the cause of the symptoms persists, their condition is soon nearly what it was not far from the beginning of treatment. You cannot claim complete recovery under the circumstances. I believe it is just here that young physicians are apt to fail

since they are surprised by the quick results obtained, and share the confidence of the patients. For the patients do not return, because they have passed from their enthusiasm to complete discouragement. They had stopped the treatment against the advice of their physician, because they had considered themselves cured, and on the first appearance of the former painful symptoms, which had been foreseen and predicted, they say that massage is no better than any other treatment. A physician who is not familiar with massage, meeting one of these patients, is apt to look upon it as they do.

The conditions for the proper application of massage differ according to where massage is performed. At the hospital the results are rather more favorable, because here the patients can be kept in bed after the manipulations, which in the beginning are often fatiguing, as they are unaccustomed to them. This is particularly so when the patients are nervous and emaciated. Several of my patients were treated at their own homes, an ideal condition; others, however, whom I treated at my office as well as those out-patients treated at the dispensary, to which the majority of the patients belonged, were unable to secure proper rest, after having to journey quite a distance and immediately take up their household duties. Under such conditions you cannot expect the best results, and yet, in the majority of cases, these were quite satisfactory.

I am sceptical as to the future of massage. Until massage is a well-recognized medical treatment in articular and muscular affections, its employment by empirics

will tend to discredit it. I am sorry to say that even to-day, as it was twenty-five years ago, no distinction is made in this country between the scientific masseur and the empiric one. If the empirics have some success, which is noised around, they also have many failures. With massage, one must be cautious, as with all therapeutic measures; it is efficacious when applied to proper cases, and sometimes dangerous when its use is contraindicated; this remark applies particularly to the kind of massage here spoken of. I do not fear empirics taking up and improperly employing massage of the uterus and its appendages as much as midwives. Many do not limit themselves to simply assisting at normal confinements, but believe themselves possessed of gynecological knowledge, and do not hesitate to practise pelvic massage. If by chance they ran across a favorable case, they might cure it and there would be no way to repair the evil. They will massage under all circumstances, in the face of all contraindications. I defy the physical strength of midwives to reach pelvic exudates which are situated high up. Furthermore, most of them have too short fingers. If long-continued manipulations are necessary, as stretching, or massaging large, hard exudates sometimes the size of a pear, which require great strength, they are soon tired out. When a strong, muscular man, who has not had sufficient experience, practises pelvic massage a number of times in an afternoon, he becomes tired and his tactile sense is blunted. A woman will tire out even more quickly. It has been urged that women should practise pelvic massage to

overcome one of the objections urged. Very well; but if they do undertake it, they must be endowed with exceptional strength and have sufficient technical knowledge to be able to appreciate the slightest physical symptoms which indicate the condition of the uterus, its appendages and neighboring structures. I think that you will meet very few of them who combine such qualifications. It would be desirable that gynecological massage be practised by true specialists in women's diseases, who, possessing a special knowledge, are able to add to this more or less skill acquired by experience.

This method has not only been declared to be indecent but even of being dangerous, and has been discussed at medical societies in various countries. The former unsympathetic attitude of French physicians toward this method is well shown by the fact that gynecology as a distinct branch of medicine was only recognized within the last few years, while previously it was entirely practised by surgeons, who would naturally be opposed to a method so conservative as this one. This opposition finally culminated at a meeting of the Surgical Society, in Paris, when a well known surgeon reported several cases where massage was said to have produced serious symptoms, and on that account alone it was to be condemned by the profession, thus endeavoring to deal pelvic massage a fatal blow. And what were these cases? They were cases of sarcoma, pyosalpinx, etc., i. e., the very cases in which we have urged pelvic massage to be contraindicated, and where the most exact diagnosis must be made before pelvic

massage ought properly be applied, and I ask in what branch of medicine does not the same apply? Contrary to the expectations of that surgeon who reported these cases, and his followers, the president of the society, M. Monod, professor of general surgery at the University of Paris, a broad-minded and progressive surgeon, energetically defended gynecological massage, and spoke very highly of its therapeutic merits when properly and skillfully applied. It is hardly necessary to add that the surgeon who opposed pelvic massage as well as his followers met with crushing defeat, and his paper produced an effect quite opposite to what he had expected.

Different names have been given by various authors to this mode of treatment. Some call it gynecological massage; others, pelvic massage, kinesotherapie (Stapfer), and manual treatment of female organs (Schauta). My distinguished colleague, Dr. Landowski, of Paris, who is dead some years, and who had an extensive gynecological practice, told me shortly before he died that he had very successfully employed pelvic massage in cases where he had tried other methods without avail, and that he called it the *gymnastic treatment* of the diseases of women. Giving it this name, his patients never objected to his practising the method.

The manual operative of the appendages differing in many points from that of the uterus, I purpose, in order to be clearer, to describe this later more particularly.

CHAPTER III.

MASSAGE OF THE UTERUS.

Operative Manual.

Precautions.—Difficulties.—Contraindications.

We will not take up much space in describing the *operative manual*, as it is so simple. It differs but little from the bi-manual examination. I shall give a general outline of my method of procedure. At the first visit I carefully examine the patient, getting her history and making a thorough bi-manual examination of the pelvic organs. If the patient appears to be a suitable one for pelvic massage, the first séance takes place the next day, circumstances permitting. The patient is told to completely empty her bladder before coming. Her clothing is carefully loosened and so arranged as not to expose her more than is necessary. She lies on the table in the dorsal position, with her head elevated, her legs flexed on the thighs, and her thighs on the pelvis. She is told to breathe easily, without any straining. It is well to distract her attention, in order to relax the abdominal muscles. After having the patient separate her limbs, the doctor stands at her left side, and if possible introduces the index and middle finger of

the left hand into the anterior cul de sac of the vagina, passing over the fourchette along the posterior vaginal wall, carefully avoiding the anterior wall, in order to support the anterior wall of the uterus, while the other hand grasps the fundus through the abdominal wall, at first lightly rubbing, and gradually increasing the pressure.

The fingers in the vagina must remain immovable, as they are only supporting the uterus. The skin of the abdomen moves with the hand of the physician. The external movements are made from the joint of the shoulder, and only in cases which require a great deal of gentleness, as when massaging the appendages, is it necessary to massage from the wrist. The fingers in the vagina must firmly steady the uterus, otherwise it might slip and thus cause a great deal of sudden pain, and, besides, obliging the physician to again seize the organ to replace it. This mishap will frequently happen to novices before they have acquired the requisite skill. It is sometimes advantageous to push the uterus against the posterior surface of the pubis, when you wish to exercise forcible and energetic massage. The bladder being empty, is not in the way and cannot be injured.

When there is displacement without adhesions, the uterus must be replaced as far as possible.

When the uterus is in retroversion and not appreciably enlarged, its reposition is generally easy. A pressure with the finger on the neck down and backwards often suffices to bring the fundus sufficiently forward to be grasped by the external hand and dragged towards

the symphysis. This is not the case when the uterus is enlarged and retroversion more pronounced or in retroflexion; the fundus then lying in the concavity of the sacrum, the neck pointing anteriorly, two fingers introduced into the posterior fornix will then assist in replacing the uterus. The pressure must be made toward the promontory of the sacrum to correct the displacement backwards, and then forward to place the uterus in the axis of the pelvis. If the fundus of the uterus has been raised out of the small pelvis by this procedure, the external hand, depressing the abdominal wall as much as possible, grasps, as in the case of normal position, the fundus of the uterus in order to complete the reduction.

In some patients the uterus, either retroflexed or retroverted, is momentarily fixed in the pelvic cavity.[1] I avoid making violent and repeated efforts at replacing it. I simply place the patient in the knee-elbow position and a few light blows on the lumbo-sacral region suffice, for the most part, to replace the uterus, and thus render the treatment possible. If this manipulation does not bring about the desired effect, one may with profit introduce the index finger into the rectum and thus be able to push the fundus still further forward. Should all these manipulations be a failure, there is no other recourse, provided you do not prefer to have recourse to instruments (as Sim's redresser or Küstner's method of reposi-

---

[1] Josephson thinks that in these cases there may be an adhesion between the two peritoneal surfaces, adhesion not of an organic but only of an agglutinating nature and presenting some difficulty in separating them. Sielsky has been the first to draw attention to this peculiar tendency of serous surfaces.

tion with the forceps) than to employ Brandt's "redressionstryck," which consists in carrying the tips of the fingers of the "internal" hand into the anterior fornix up to the angle of the flexion, where they are met by those of the external hand, which are pressed toward the same spot. Both hands press simultaneously on the angle and on the uterus backwards, in order to do away with the former. This done, the uterus is pushed with both hands along the sacrum towards the promontory. The uterus, now straightened, glides upwards. Reposition is then completed in the ordinary way.

If the organ is firmly fixed by adhesions and imprisoned in the pelvis, too much force must not be used in freeing it, as hemorrhage might occur in tearing the adhesions and thus give rise to serious perimetritis. Before employing massage of the uterus in such conditions, it is necessary to free the uterus by the manœuvres described later on. The following precautions will render massage easier and more bearable:

First—Pressure upon the fundus must be gradual after it has been seized.

Second—In order to get a good hold on the fundus, you must press the abdominal wall during forced expiration; at the next inspiration, hold it firmly and then press still further at another expiration. This must be continued until you can seize the organ as well as possible.

Third—Avoid quick and sudden movements, when seizing the fundus through the abdominal wall, as these cause pain. Pause a moment before applying friction.

Fourth—Devote your entire attention to holding the uterus properly. This is easy when the uterus is large and soft, but difficult when small, hard and globular, for then it will slip from one side to the other. In the treatment of cases of chronic metritis, toward the end of the treatment, when the uterus has become reduced in size and increased in consistency, this frequently happens.

The intrinsic value of massage may be gleaned from my cases, which have a great interest, as it was the only treatment employed. Only toward the end of the treatment, after their local condition became satisfactory, did I sometimes advise hygienic measures. Some patients, at this time, are deceived. They have frequently told me, "I am better; I do not menstruate so profusely; do not complain of any pains in the back or sides. But this is not all that I expected; my strength and appetite do not return." I assure them that their general condition will be excellent in a month or two, and I have rarely been mistaken in this. There are few remedies which can remove the underlying disease and its complications in such a short time. The cause having been removed, the rest is but a matter of time. At this time I only prescribe from time to time tonics, or send them to the country. Hydrotherapy, gymnastics and sea baths are useful, and in a short time the reflex symptoms will disappear.

The treatment is well borne, in spite of the pain, for the pains will cease after the séance is over. I always give the advice, which I cannot repeat too often, namely, you must employ gentleness at the beginning of every séance, gradually increasing the

pressure. You will succeed much better in this way than if you use too much force. A description of this method can never give the proficiency which practice alone can give. To those who would learn how to massage the uterus, I would say: Carefully select your first cases, for that is all important; choose only thin women or those with flabby abdominal walls. After you have cured some few cases you will have gained confidence; your fingers will be able to differentiate the various conditions of the uterus and conduct proper manœuvres. When you have treated twenty or thirty cases, you will then apply massage in conditions in which formerly you would not have dreamt of massaging. Generally the séance does not last more than four or five minutes every day. Two séances a day would be preferable in some cases, provided they could stand it, which is rarely the case. The average duration of the treatment is from forty to fifty days. When begun shortly after the onset of the disease, it is of course shorter. When patients come to me just before a menstrual period, I wait until it is over, and begin right after, for the following reason: Suppose the period occurs every twenty-five days; I am able to give twenty-five séances, and in ordinary cases, I only have one interruption. It is well to remember that menstruation may occur earlier and be a trifle prolonged by the treatment.

The main difficulties encountered are:

First—An extremely hyperesthetic and tender abdominal wall.

Second—A fatty abdominal wall and intestinal distention.

Third—The presence of irreducible hernias.

Fourth—A small vagina.

And I might also add general hyperesthesia and nervousness. Those belonging to the first two categories are relative. With practice and perseverance on the part of the physician, tolerance is established and the procedure may be practised with ease. It is only necessary to massage the abdomen a short time in order to accustom it to the hand. Brandt spoke of uterine massage as applied in this way alone. It has also been proposed to support the uterus by the finger inserted into the rectum. I have only used the latter procedure in the case of virgins. The indications for the use of this procedure seem to me rare. When the vagina is narrow I use only one finger flexed. Attacks of acute and sub-acute metro-peritonitis occur infrequently, and only as the result of too much force in the hands of novices. They may occur when the patients disobey the physician's directions and act imprudently. I always advise my patients to remain in bed during the menstrual period, which may occur during and right after the treatment. Some disregard this advice with impunity, others pay for their imprudence with local inflammations.

When dealing with a nervous, emaciated woman, it is well to advise rest—even rest in bed for one or two hours after the seance. This short rest is of great benefit to

the patients and enables them to better undergo the treatment.

I only recognize three absolute contraindications: Virginity, and this is not even absolute; acute or sub-acute inflammation of the uterus and its appendages, and pregnancy. As to the latter, we have seen women become pregnant during the course of the treatment and go to full term. These, however, may be exceptions. When a menstrual period is delayed, or is absent, the treatment must be suspended.

It has been feared that pressure on the uterus would cause complications. I have not had any. They are more to be feared after a bloody operation, however slight, than after a procedure in which neither a vessel nor tissue is torn. From the first I always take rigorous antiseptic precautions. The accidents I have seen have been insignificant, and only exceptional. I need hardly mention them—ecchymoses of the abdominal wall, slight indurations of the subcutaneous tissue, which are tender and must be avoided while massaging, cases of vaginitis so slight which do not even necessitate discontinuance of the treatment, and which have been benefited by tampons of alum. I have twice seen inflammation of the vulvo-vaginal glands accompanied by a slight febrile movement and slight local swelling. These did not suppurate and were undoubtedly not of blenorrhaic origin. After suspending the treatment for two days I was able to resume it.

These are some of its disadvantages, which are extremely slight when compared with its great advantages.

You can massage the uterus at any time, *under the clothes*, which makes it as modest as possible, particularly if compared with other methods of treatment. The patients continue their occupations. I only ask them, as I have already mentioned, to stop work during menstruation (that is, during the period which occurs in the course of the treatment and the one following it). At other times I only prohibit laborious exercise and long walks.

CHAPTER IV.

CHRONIC METRITIS.

Difficulties.—Different Methods of Classification.—Their Disadvantages.—Cursory View of the Pathology and Principal Symptoms.—Parenchymatous Metritis and Endometritis.(1).

Since pelvic massage has been declared indecent and even dangerous, let us now see whether it is also useful. If so, then it is proper and its future is assured, in spite of the objections raised against it. We shall endeavor to show in which conditions it is useful.

Although this chapter is principally devoted to treatment, I must devote some space to uterine pathology, as this, in my opinion, will render the subject more interesting and more easily understood. I have collected a large number of my cases and placed them in this chapter on metritis. The others are described in the chapters devoted to para- and peri-metritis, fibroids, prolapse, etc. If all who write about metritis would use the same

[1]The following chapter on *chronic metritis* is almost a repetition of that in my book on "*Massage of the Uterus*," published in French in 1889, and expresses the opinions held especially by French and German physicians at that time. In looking over works on gynecology published since that time in different countries I find that nothing essential needs to be added. Even the latest work published on this subject by Doleris, "Metrite et Fausses Metrites" (Paris, 1902; 588 pages), which only fell into my hands after this article had been written, does not contain anything new of importance.

classification, the various articles would only differ in details. If we confine our attention to the chronic forms of inflammation and leave aside the acute, the subject will not be incomplete, as massage is not indicated in acute inflammations.

In the first place, we must take up the histology of these particular lesions. When normal, the uterus is composed of connective tissue, unstriped muscle, blood vessels, nerves and glands. It is necessary to determine whether there are any changes in these elemental structures in a given case, and whether these changes are similar to those occurring in other organs. It would then be possible to determine wherein these inflammatory changes differ from similar inflammations in other organs. The problem has more than once presented itself and has never satisfactorily been explained. We shall find many different opinions in regard to the affections we are about to describe. Aran, describing a condition of the uterus characterized by a persistent hyperemia and interstitial exudation, agrees with Robin, that the semi-liquid exudate became organized and tended to increase the size of the uterus; but he did not wish to be understood as saying that the inflammation or hypertrophy was due to the engorgement.

Kiwisch considered this a chronic phlegmasia[1]. Becquerel, giving up the idea that it was due to a chronic engorgement, declared that this name had been applied to a chronic inflammation—to a hyperemia—to a hyper-

---

[1]Klin, Vorträge 4te Aufl., p. 580.

trophic congestion. His rather lengthy descriptions of the last two conditions do not aid us in distinguishing the one from the other[1]. Nonat categorically declared that all the engorgements were inflammatory; Hugier[2] did not say so, but his descriptions indicate that his belief was that it was different. H. H. Bennett also believed this. He defended and popularized the idea that chronic metritis includes everything described under the names of congestion, engorgement, hypertrophy, etc.

The pathologists differed as well. Rokitansky[3], in place of the clear description which one would have expected in his complete and classic work, declared that chronic metritis might develop after acute inflammations of long duration and that engorgement followed. Forster[4] said the same thing in different words. Scanzoni, in reviewing the previous literature, together with his personal experience, concludes as follows: "The term chronic metritis is not properly applied to all cases so called. Even many engorgements of the uterus which are looked upon as inflammatory are not inflammations in the strict sense of the word; they are disorders of nutrition, which is often seen in other organs as the result of a persistent venous stasis[5]."

Those who admit this more frankly do not even agree on all points. Mm. Demarquay and Saint-Vel have

---

[1]Traité clinique des maladies de l'uterus, II, p. 557.
[2]Traité pratique des maladies de l'uterus, Paris, 1860, p. 112.
[3]Pathologische Anatomie; 3te Aufl., III, p. 477.
[4]Spec. pathol. Anatomie, p. 134.
[5]De la métrite chronique trad. par Siffermann, Paris, Masson, 1866.

written chapters on parenchymatous metritis, chronic corporeal endometritis, on the chronic metritis of virgins, etc. According to Martineau, endometritis ought to be divided into constitutional and non-constitutional; it is difficult to differentiate the two. Courty has made a more complete classification. He has gathered under one head the elements of all the classifications imaginable. In order to find a suitable one it is only necessary to select according to one's own judgment or needs. They may be brought under the following headings:

First—According to the location and extent of the inflammation, a general or a circumscribed metritis.

Second—According to the portions of the uterus involved, a total or partial.

Third—According to its course, acute, subacute or chronic.

Fourth—According to its etiology, a puerperal or non-puerperal metritis.

Fifth—According to the second classification above mentioned, it may be a traumatic or diathetic metritis.

Sixth—According to its termination, it may be suppurative, fungoid, etc.

Seventh—From the histology of the different layers involved you may describe, an endometritis when the mucous layer is chiefly involved, a parenchymatous metritis when the changes are localized in the parenchyma, and a perimetritis when the parietal layer is involved.

Eighth—According to the structures involved a

fungoid vascular metritis, hemorrhagic metritis, etc., may be described.

Ninth—According to the accompanying symptoms, metritis may be simple or complicated.

In spite of the large number of subdivisions, Courty does not include under metritis all that others have embraced under the term. "Many," says he, "hesitate to include under this head certain morbid conditions which are often the forerunners and prepare the way for it, as discharge, congestion, and even a large number of diseased conditions which are the results or the consequences, as hyperemia, œdema, hypertrophy, granulations, ulcerations, etc. I do not deny that some of these morbid states might cause the first stages of inflammation and that others only frequently represent the final results. But is it necessary to include all these morbid conditions under the title of inflammation, and is anything gained thereby? As I have already said with reference to inflammation, every time I found in a morbid state definite characteristic and diagnostic symptoms, and an indication for treatment, such as I have grouped under the synopsis, I felt obliged to describe it as a special morbid condition, and not as a simple stage of inflammation."

These ideas may be defended; the data on which they are based are real, but truly if the same rigorous rules of diagnosis are to be applied in uterine diseases as in diseases of other organs, a nomenclature based on the classification of Courty would frequently cause more confusion than one would believe. Wherein does fluxion

differ from inflammation, and inflammation from engorgement? Granting that we have arrived at a strict and careful analysis, we have then made a distinct advance; that we have gone further; that we have determined the seat, character and extent of the inflammation, then the conclusion must be drawn that following conditions exist.

Endometritis, chronic, partial, limited to the body of the uterus, non-puerperal, diathetic, proliferating, hæmorrhagic, uncomplicated.

This classification is based on clinical observation; nothing that it contains is useless; all serve for prognosis; all furnish indications for treatment. Is it necessary to embrace them all under one head? To give to the nosology this close definition? It appears to me less trouble to arrive at a clear comprehension of what one observes, and to then state what you wish to treat, without all these terms. Some simple facts and a little discussion of the general pathology will allow us to do this. The first and most natural division, according to the rapidity of the process, is into *acute* and *chronic*. The former does not concern us.

Chronic inflammations may present themselves as follows: First, as hyperemia; second, as exudation; third, as organization of the exudate. If we put aside the first two forms, being those which are met with more frequently, we shall, as just mentioned, have to deal with organization of the exudation; that is to say, hyperplasia of the tissues and hypertrophy of the organ. Admitting, as is usual, that those can exist sim-

ultaneously, i. e., in one region of the mucous membrane or the parenchyma, of the cervix or body, you may have here a recent fibrinous exudate; whereas, in another portion, others have passed into the stage of connective tissue, hyperplasia, and around it the dilated veins are engorged with blood. You may say that hyperemia accompanies the other two conditions. This polymorphism occurs naturally, corresponding to the irregularities of the process, and is observed in all forms of chronic metritis. We have already quoted a number of paragraphs from M. Courty, and may readily discard the terms congestion, engorgement and hypertrophy. On the other hand, it is difficult to imagine a morbid process distinctly limited to one portion of the uterus. At times the inflammation involves one portion more than the other, but you can hardly conceive of the cervix being normal when the body of the uterus has been long affected. Is it possible for the muscular fibres of the uterine wall to be intact when a chronic endometritis exists? Hardly; for our definition includes all the structures. Stokes has formulated the following law: That a long-continued inflammation of a mucous membrane brings about inflammation and paralysis of the underlying muscular fibres; this applies also to the uterus. Its mucous layer does not escape when there exists a parenchymatous inflammation[1]. Strictly speak-

[1]It is curious to observe how many authors discuss chronic parenchymatous metritis with only scant attention. The word *endometritis* is mentioned over and over again, whereas the term parenchymatous metritis is scarcely alluded to, and, if mentioned, only *en passant*. I am glad to see that Doleris, in the work mentioned, does make an exception in regard to this, and tries to give parenchymatous metritis the place in the pathological anatomy of metritis which it undoubtedly deserves.

ing, taking account of the anatomical changes, everything could be described under the general term chronic metritis. The symptoms, especially if closely studied, as we have done, after applying massage, indicate this. The principal objective symptoms of chronic metritis are changes in the shape, consistency, size and structure of the uterus, or its component parts. The subjective symptoms are disturbances in function, especially acquired sterility, localized pain, dysmenorrhœa, metrorrhagia and leucorrhœa. These symptoms may be present in every case of metritis, but when certain symptoms predominate, either the cervix or the body of the uterus is more affected.

Discarding for the moment the relatively less frequent disease described by various authors under the name hemorrhagic metritis, fungoid or non-fungoid, we describe two varieties of metritis, *catarrhal* and *parenchymatous*. I do not wish to say, however, that the muscular tissue is the only seat of the inflammation at the outset. On the contrary, it is probable that the affection arises in most, if not in all, cases from the mucous membrane. But when the patients come for massage treatment the disease has existed a long time, often after having undergone various methods of treatment, the parenchyma is no longer normal, the morbid process having extended, and there exists a parenchymatous metritis in the strict sense of the word. That it has existed from the beginning is of little importance, if it has contributed to the type and course of the disease.

CHAPTER V.

Chronic Metritis and Its Consequences. — Anatomy of the Uterus. — Predominance of Venous over Arterial Supply.—Nerve Endings.—Influence of Parenchymatous Inflammation upon the Mucous Membrane.—Venous and Lymphatic Stasis. — Hæmorrhage. — Leucorrhœa.— Possibility of Impregnation?—Acquired Sterility.—Influence of Massage.

Chronic inflammation of any organ has an influence on the structures in its immediate vicinity, as well as remote organs. Through extension of the process, various reflex symptoms arise, among which the most important are circulatory and reflex nervous disturbances. Later on, when the organ increases in volume and when its nutrition has suffered, it becomes, in a great many cases, so flabby that it seems hardly credible that it can withstand the secondary results which make us mindful only of the consequences, and not of the original affection. Since the blood vessels and nerves are at fault, one might conclude that there exists no contraindication to massage, as in these very conditions it is one of the most certain and best remedies that can be employed.

Before studying the clinical features and the pathogenesis of chronic metritis, it seems well, without

discussing the anatomy of the uterus, which is already well known, to briefly allude to certain peculiarities in its structure, which have an important bearing in this connection. The distribution of the arteries and veins is clearly described, and the latter have a greater capacity than the former. It is for this reason that gynecologists of the old school have so long desired to lay emphasis on the distinct and essential congestion. In a medium so richly supplied with veins, a limited focus of inflammation is surrounded by an extensive and indistinctly limited zone of venous stasis. M. Mayrhofer has described with great precision this disproportion between the arterial and venous supply. "When the vessels of the uterus are injected—the veins and arteries with different colored injection-mass, one is struck," says he, "by the great preponderance of veins over arteries." The blood supply of the uterus is derived from the utero-ovarian and the uterine arteries. The former, lying between the layers of the broad ligament, having left the inner border of the psoas, supply the ovary and the tube. They give off small branches to the body of the uterus and anastomose with the uterine arteries.

The uterine arteries, which are the more important blood supply to the uterus, are derived from the hypogastric arteries at the inferior border of the broad ligament. They pass to the cervix and give off a few small branches to the vagina, and then pass upward along the side of the uterine body to the fundus. In nulliparæ these arteries are straight; in pregnancy they are con-

voluted. This condition remains after confinement and involution of the uterus. The only modification that occurs is narrowing of the spirals and the lumen of the vessels. It is thought—erroneously, I believe—that the flow of blood is impeded by the vertical position of the vessels since gravity must be overcome. Too much importance has been given to the direction of these vessels. This is what Hyrtl says in his *Traite d'anatomie topographique,* of these spiral vessels: "The spiral course of the uterine arteries is the result of that physical law by which the movement of a fluid from below upward is easier in tortuous than in straight vessels." It is unnecessary to look for an adjuvant to the heart in the shape of the uterine arteries, for we do not have to deal with rigid tubes, but with elastic vessels which dilate and lengthen at each pulsation, and whose change in volume is a result of the resistance before and the pressure of the blood behind. But it would be a gross error to suppose that a longer tube better overcomes the friction of the blood flow than a shorter canal of the same diameter.

It appears to me that if these affections due to uterine congestion disappear more readily in nulliparæ than in multiparæ, we can infer that this is in great measure due to the diminution of the blood pressure resulting from the tortuosity of the vessels. What is the cause of this arrangement? That is the province of the gynecologists to explain. Moreover, we have another example in the spiral arrangement in the vessels of the umbilical cord. No satisfactory explanation has

thus far been given. This is what is observed every day, and on account of its frequency, is not considered worthy of serious study. We must confess that all that has thus far been done has been accomplished by imperfect and insufficient researches, disproportionate to the difficulties presented by the problem. Physiological investigations ought to take precedence over mechanical ones. It is unnecessary to add that this is a difficult problem, for which there appears to be no ready solution. The uterine venous supply presents greater importance from the point of view of circulatory disturbances. The veins empty, partly into the uterine plexus situated to the right and left of the uterus, between the layers of the broad ligament, and partly into the pampiniform plexus, which communicates with that in the upper part of the same ligament. The latter also receives the veins from the ovaries and tubes. From this plexus only a few branches go to the utero-ovarian veins. This network of vessels has a very large capacity and it is surprising how large a quantity of fluid is required when these vessels are to be injected. This plexus of large veins has no valves; neither have the veins of the uterine parenchyma; whereas, the veins in the neighborhood of the uterus have few and unimportant ones. All these venous spaces are extra-peritoneal. The pressure in them corresponds to the intra-abdominal pressure, which is greater than the atmospheric pressure. This arrangement explains many of the functional disturbances and morbid phenomena whose importance we have discussed in the chapter on chronic metritis. The

author we are about to quote has made similar observations. "The frequency of passive congestion is not surprising. The slight *vis a tergo* of the arteries hardly has sufficient power to drive an equal volume of venous blood before it. The question arises, why are these congestions not present in every woman?" The quantity of blood increases at each menstrual epoch, and the *vis a tergo* diminishes in feeble, anæmic patients in whom the contractions of the heart are weak.

The lymphatics present a similar course to that of the veins. According to the researches of Leopold, made fifteen years ago, the greater portion of these are seated in the mucous membrane, where they form sinuses ending in infundibula. They communicate with others less numerous, in the muscular coat, passing into the subserous layer, where not many lymphatics are present, forming a network less abundant than that of the blood vessels, anastomosing with the deep lymphatics and dividing into two main groups on each side. The lower group is formed by vessels coming from the cervix and emptying into the lateral pelvic ganglia. The upper group empties into the lumbar ganglia[1].

The nervous mechanism was well studied in 1867 by Frankenhauser. The nerves are derived from the cœliac plexus, through branches from the venal plexus, and passing through the inferior ganglion, are distributed to the ovaries and genital ganglia. This receives four branches from the sympathetic axis and supplies the ovaries. The great uterine plexus is situated

[1]Archiv. für Gynäkologie, Bd. VI, Hft. 1, 1373.

below the origin of the inferior mesenteric artery, and is formed by filaments derived from the genital and lumbar ganglia of the sympathetic. On each side of the cervix there are large ganglia, from which most of the nerves supplying the uterus are derived. The remainder come from the hypogastric plexus[1]. Frankenhäuser has not been so accurate in his description of the nerves in the uterine parenchyma. He has described medullated nerves as being present in the external layer of the gravid uterus; in the non-pregnant uterus there were nerve plexus of non-medullated fibres. According to him, then, pregnancy would transform non-medullated into medullated fibres, and would cause an increase in the nerve supply of the uterus. The relation of the nerves to the mucous membrane and the glands is very vague. Do these nerves end there? Frankhäuser's work does not mention this.

Dr. F. A. Patenko, a Russian anatomist, has endeavored to clear this by some researches on a uterus recently removed by vaginal hysterectomy, for a circumscribed cancer of the cervix. His conclusions, read before the medical society of Russian physicians, of St. Petersburg, at a meeting on September 25, 1880, were as follows: "In our preparations we observed that the cul-de-sacs of the glands were surrounded by a rich network of non-medullated fibres. This network extends from the outer surface of the mucous membrane proper to the inner layers of the submucous connective tissue and entering into connection with the glands and form-

[1]Die Nerven der Gebärmutter, Jena, 1867. in fol. 8 pt.

ing a sort of support for the epithelium. From here we can trace the nerve fibres further inward. They are distributed among the epithelial cells. There they are lost, and again can be traced in the glandular epithelium. We have been unable to trace them any further. In the superficial nerve plexus small nerve cells are found.

"We must be cognizant of the fact that within the muscular and mucous layers of the uterus we frequently see small plexuses formed by 3 or 4 non-medullated nerve fibres, and in the same layer some small ganglion cells giving off fibres. Then, again, there are other facts to be considered. The great majority of the uterine glands have their cul-de-sacs in the intermuscular connective tissue, between the diverging bundles of interlacing muscle fibres. (Leopold.) We may admit that it is probable that the nerve plexuses seen by us among the mucous glands have their origin in the fibres and nerve plexuses which are present in the intermuscular connective tissue.[1]

We have now discussed what is essential in order to understand the chief phenomena causing chronic metritis and its treatment.

We have hardly given the etiology any attention. According to Courty, the cases are either puerperal or non-puerperal. Gallard has described a type of metritis occurring in young nulliparæ which is acute and not susceptible of treatment by massage. In nearly all of

[1] Ob okonichanii nervov v lizisloi Obolchtchkie matki. Troudy Obchtchesva Rousskik Vratchei t V. St. Petersburg, 1880, p. 11.

our cases the disease followed pregnancy, abortion, labor and their sequelæ. Patients were unable to give a description of their initial symptoms, but recall that they came on after a miscarriage or a short time after the birth of their baby.

It is astonishing how very few patients affected by endometritis or chronic metritis of gonorrhœal origin came to us for treatment, and this affection is not uncommon, at least in Paris. Yet there are many peri-uterine affections of which we shall describe some later on which might have been due to gonorrhœa.

We do not wish to be understood as claiming that there does not exist a metritis (endometritis) where one of these causes has not been operative, where its cause is some general disease, as chlorosis, or has not been ascertained.

We may safely say that chronic parenchymatous metritis is usually the result of an acute inflammation of puerperal origin. Mostly when we see these cases for the first time the stage of active congestion has passed; we have an exudation and organization of the exudate. After careful examination we suppose it to be limited to the muscular layer. This is only applicable to a limited number of cases. In the majority of cases the metritis is mixed, i. e., parenchymatous and catarrhal.

We have an interstitial exudation, causing a mechanical obstruction to the circulation, which is more or less responsible for the persistent congestion of the mucosa, accompanied by leucorrhœa, increased desquamation of

the epithelium, together with general symptoms depending upon the seat and intensity of the inflammation.

Leucorrhœa.

I have treated, with good results, several cases of leucorrhœa, which is, as is well known, one of the most frequent manifestations of chronic metritis (endometritis),[1] and which is, moreover, the one that the patients most frequently desire to get rid of. I must confess that this affection is one of the most difficult and obstinate to cure, and, if cured, is generally the last one to disappear. This is probably due to the fact that the endometrium can only be influenced through the thickness of the uterine wall, and it appears to me that massage only produces its good effects here in cases where the uterine wall is more or less softened.

Leucorrhœa is particularly obstinate in cervical catarrhs, where the discharge is mucoid, tenacious, stringy and more or less transparent. This secretion as a rule changes its character before it disappears, and becomes thicker and whiter. This I have often observed in my practice. In most of the cases here reported this symptom is met with. In two of them, which immediately follow here, it was very abundant, and yet it ceased completely, as there was no relapse within two years—a

[1] I cannot help briefly alluding, in several parts of this work, to some symptoms of chronic metritis in the uterus itself or its neighboring organs, which are all the more important as they are favorably influenced by massage. These are *Leucorrhœa, Hemorrhage, Sterility, Bladder Irritations, Constipation* and some forms of *Dysmenorrhœa.* In speaking shortly of these it seems to me that the matter is all the more interesting, as the exposé of every one of them is followed by some observations referring to them.

fact all the more remarkable, as a leucorrhœa, once cured, frequently relapses. Within the last few years *curettage* is done not only in fungoid hæmorrhagic endometritis, as formerly, but also daily in chronic endometritis, i. e., uterine catarrh. I wonder how a procedure like this can have any influence on the inflammation of the uterine parenchyma, which always coexists to a greater or less degree with the endometritis, when the latter has been of long standing. It appears to me as if, when the mucous membrane is regenerated and the connection between the endometrium and parenchyma re-established, the previous morbid symptoms would easily return, since they have the same blood, lymphatic and nerve supply. This is just what frequently happens, and I attribute to this the frequent relapses. I have seen one, two and even three relapses follow curettage done by some most skilful gynecologists.

Besides, to pretend to cure cervical catarrh by curettage seems to me to be an illusion which the most primitive anatomical knowledge will be sufficient to destroy. While the follicles of the mucous membrane of the body are very simple in their structure, dichotomically ramifying, if at all, only in the depths, and ending where the underlying muscular tissue begins, not penetrating into it, the glandular apparatus of the cervix is more complicated, having the shape of racemose glands, penetrating sometimes deeply into the thickness of the muscular tissue. Although Dr. Doléris, in the book mentioned,[1] appears to be in favor of curettage as far as it is em-

[1]Metrites et Fausses Metrites.

ployed in cases of catarrh of the uterine body, he is not convinced of its utility when dealing with cervical catarrh. "Attain, with the curette," he says, "the diverticules of the uterine neck, seated in the trabeculæ of the stroma, the anfractuous follicles, where the morbid process takes its refuge and persists in preference, is something quite impossible. *The curettage cannot cure the cervical metritis.*"

As, in addition, any complication of the appendages constitutes a contraindication to the application of curettage, and as these complications are very frequent, it is easy to understand that the number of cases susceptible to this method must be rather limited.

I am at a loss to explain how massage acts upon uterine catarrh. It may be that massage indirectly influences the uterine mucosa and its glands through the parenchyma, which is in close connection, as the anatomy indicates. In cases of retention of mucous in the uterine cavity, as in some cases of retroflexion with a very acute angle of flexion and atony of the uterine walls, massage may also act favorably in restoring its contractile power and thus counteracting stagnation. By this means the retained mucous is prevented from exercising a deleterious influence upon the mucous membrane of the uterus, and from increasing the secretion; massage acts, to employ a French term, as a "detergent."

OBSERVATION I.

Chron. Metritis.[1]*—Profuse Leucorrhœa.—Massage.—Cure.*

Mrs. N., 28 years of age, the wife of a police officer. She has been confined four times. Her last confinement was followed by severe uterine inflammation. This patient, pretty feeble and of a scrofular diathesis, has always had slight leucorrhœa since the appearance of her menstruation, at the age of 16. Leucorrhœal discharge was more pronounced after the periods.

Since her second accouchement her health has been more feeble than formerly. She has always experienced a dull pain in the back, with a painful sensation of pressure in the hypogastric region. Frequent micturition; palpitations of the heart; leucorrhœa, muco-purulent in character. As we have stated before, her ailment began at her last confinement, in March, 1875. She attributes all her symptoms to this. Her weakness increased gradually to such an extent that after the slightest effort she is obliged to rest several times during the day. She has become extremely sensitive and irritable. On the slightest provocation the patient complains as though her chest was in a vise. Discharge is profuse. Erythema about the vulva and along the inner surface of the thighs. So far she has used vaginal injections of tannin solution and direct applications of silver nitrate. These procedures, together with hydrotherapy, produced but transitory diminution of the leucorrhœa.

When I examined the patient for the first time, in December, 1876, in the clinic of Dr. Pacquelin, I found the uterus increased in size, without any displacement. Length 7.50 cm. Freely movable and of rather soft consistency. The cervix is large, slightly lacerated on the left; "Emmett operation" indicated, but not practicable. There is also a superficial ulceration in the posterior lip extending even into the cervical canal.

During the first séance of massage, on account of the manipulations, a quantity of fluid which had apparently accumulated in the uterus was observed to flow from the uterus. It was of the quality described as above. The leucorrhœa is so profuse that when the patient is about to submit to the treatment it falls in big lumps on the floor, discoloring the latter and rendering it necessary for the nurse to wipe it up.

The amount of discharge diminishes gradually, and at the end of seven weeks it is quite insignificant. The patient considers herself cured. She has gained strength so that she is now able to attend to her household. Pains are absent; there remains only frequent micturition. Her general condition has improved. The attacks of migraine that caused her so much suffering before have become less frequent. The uterus has diminished in size, being now of normal length and consistency. The ulceration disappeared without any treatment. At

[1]When I, in the following observations, speak of chronic metritis I include in that name always the parenchymatous and catarrhal form.

the following menstrual period she had a slight leucorrhœal discharge at the end of it. For three weeks she is not feeling quite so well. All this disappears after several séances of massage.

I saw this patient eight months later. She informed me that the leucorrhœal discharge had stopped since her second menstruation following the treatment.

I saw her again eleven years after the end of the first treatment, i. e., in May, 1888. In those eleven years she has had three confinements, the first absolutely normal and without any untoward symptoms. At the end of the second she was obliged to stay in bed for six weeks on account of a pelvic peritonitis on the right side. The symptoms following her last confinement were very serious. It was followed by leucorrhœa, pains in the back, constant fatigue, and by such extreme weakness that the patient could hardly walk.

The uterus is in about the same condition as when I examined her the first time, in 1876. She also presents a diffuse infiltration in the broad ligament extending to the ovary. I massaged the infiltration specially, as it was easily accessible on account of the extremely flabby abdominal wall. The result has been most striking. After two weeks' treatment the leucorrhœa had already greatly diminished and the patient felt much better. Five weeks later the cure was complete. The uterus had assumed its normal size. No trace of any exudations. Toward the end of April her general condition excellent. No more discharge.

OBSERVATION II.

Chron. Metritis. — Various Nervous Symptoms. — Leucorrhœa. — Incomplete Hemiparaplegia on the Left Side.—Massage of the Uterus.—Amelioration.

Mrs. D., 34 years of age, the wife of a musician of the Republican Guard, came to the clinic of Dr. Péan at the beginning of January, 1877, leaning on her husband. She was so weak on her left leg that she was unable to walk without support. This trouble dates back four years. The patient ascribes it to her only confinement, which took place at that time. It was accompanied by profuse hæmorrhages and followed by a sanguinous discharge which lasted about a month. These affections reduced her to such extreme weakness that the patient was unable to leave her bed for 2½ months. At the same time she experienced violent pain in the back, accompanied by a hypogastric sensation of pressure and leucorrhœa, the latter at times bloody in character.

At the beginning of her trouble she noticed only a slight weakness in her limb, especially marked at the time of her menstruation. This weakness gradually increased to such a degree as she now presents, and which has persisted without any appreciable modification for three months. Sensibility is intact; in fact, it seems rather increased than decreased. Lower extremities present nothing abnormal; menstruation irregular; dyspareunia; irregular neuralgic pains in different

parts of the body. The slightest cause excites her. Hysterical attacks. The physician who treated her at the beginning enjoined absolute rest, prescribed daily purgatives for the last week and purgatives every other day for a fortnight following. For the leucorrhœa he prescribed vaginal injections of tannin. As a result of this treatment the discharge stopped almost entirely, but the other symptoms seemed to be aggravated rather than attenuated. A second physician who treated her since January, 1876, cauterized an ulceration of the cervix and prescribed hydrotherapy. For several months constant discharge. These modes of treatment produced, in spite of all, but transitory improvement. The weakness of her limb persisted as pronounced as before treatment was begun. At the time I saw this patient I found the uterus enlarged, in its normal position, movable; no pain on touch in the anterior or posterior cul de sac; the cervix smooth. Its orifice discharges a viscous fluid.

Massage of the uterus. After eight weeks' treatment there still remains slight weakness of her limb, but she is able to walk for several hours without any support and come to the clinic of St. Louis Hospital. The other symptoms have to a great extent disappeared. There remains but a nervous excitement, which abates after a few months' sojourn in the country. The whitish discharge disappeared after having assumed during the last two weeks a rather thick consistency. She was seen by Dr. Péan on March 18, 1877.

OBSERVATION III.

Chron. Metritis.—Slight Descent and Antiflexion of the Uterus.—Dysmenorrhœa.—Profuse Leucorrhœa.—Massage.—Cure.

Mrs. T., 28 years of age, the wife of a non-commissioned officer in the army, has complained of dysmenorrhœic symptoms since her second confinement, three years ago. The patient is weak and of a delicate constitution. She began to menstruate at the age of 15, and menstruation was always regular up to the time of her marriage. She got pregnant for the third time, when she expected to be free from those attacks. This pregnancy was terminated by a miscarriage at the fourth month. She had hardly left her bed when the pains started again. The slightest pressure on the abdomen excited a painful sensation toward the vulva and the perineum. Constant pains in the back; frequent urination; discharge, profuse, thick, yellowish, sometimes bloody; great lassitude. She is not able to go up a flight of stairs without being extremely exhausted. She entered the Hospital Beaujon. Warm baths every second day, cauterization of ulcers, vaginal tampons soaked in alum solution. At the end of two months her periods returned normal in quantity; injections of starch solutions containing laudanum had no effect on the dysmenorrhœa.

After a stay of six weeks in the hospital, she leaves after having experienced a slight improvement.

Later on electricity was directly applied to the uterus, but without

success; frequent desires of micturition (16 times in 24 hours), accompanied by a burning sensation in the urethra. The urine is pretty clear. Work of any kind is impossible; extreme mental weakness. She enters Dr. Pacquelin's clinic in March, 1878.

Slight vaginal descent and anteflexion of the uterus; walls flabby; the cervix smooth, without any alterations except the cicatrices resulting from previous cauterizations. The whitish discharge is so profuse that on withdrawing the two fingers introduced into the vagina, in order to massage the uterus, the hand is covered with a whitish, mucoid fluid. Massage reacts rather quickly. The patient, who is extremely weakened by her condition, submits to the treatment with absolute regularity. The first menstrual period following the commencement of the treatment is normal and almost without pain. The desires at micturition are markedly diminished, 5 or 6 micturitions a day at the most. Hypogastric pressure much less painful than before; the patient is now able to tend to her ordinary household duties without any trouble. Already after four weeks' treatment the leucorrhœal discharge has markedly diminished, and at the conclusion of the treatment it has entirely stopped, and the patient declares at this moment "to feel quite dry." Treatment lasted about 50 days.

I have seen this party several times since; she feels very well. It is not quite a year that the patient noticed a slight discharge preceding menstruation (1885).

I shall now discuss a symptom which is not uncommon in the course of chronic metritis, i. e., endometritis, namely, *Uterine Hemorrhages.* Generally menstruation is prolonged in this condition. This can only be regarded as abnormal if the flow lasts longer than ordinarily. Hemorrhages occur also in the intervals between the periods. Generally the interval is shorter and frequently the period lasts so long that there is almost a constant flow, and the patients are unable to definitely say how long the period really lasts. It is not surprising that the patients become anæmic. I have often wondered how some of them can sustain such a great loss of blood for a long time without becoming markedly weakened thereby, provided their appetite and digestion remain good. Massage must be employed here in a very gentle manner.

otherwise the flow is apt to be increased instead of diminished; there is, moreover, no reason for pressing hard, as the uterus is in these cases commonly of a soft consistency, consequently massage can more easily act upon the parenchyma, and through the latter, upon the endometrium, the seat of the hemorrhage. Following Brandt's advice, I have often radically cured cases where improvement had been despaired of, and where the hemorrhage had been so abundant that, on withdrawing the two fingers, not only the hand but even the forearm were covered with blood. I do not deny that the time required to cure these cases was very long (two to three months). I have formerly applied massage in *fungous hemorrhagic endometritis*, where the symptoms were menorrhagia (metrorrhagia), enlargement of the uterine cavity and almost always without any evidences of catarrhal inflammation, contrary to what is present in the previously described form. Unfortunately the diagnosis was not always confirmed by microscopical examination of scrapings. I have obtained some results, but in the majority of my cases the treatment entirely failed. I have therefore abandoned it in these cases.

We do not obtain a permanent cure with massage alone, but I believe it constitutes the most valuable adjuvant in the treatment of this last mentioned disease. How frequently we meet with relapses after curettage, even after the most thorough scraping, when no granulations remain behind, and proper cauterization of the interior of the uterus has been employed. These relapses, as above mentioned, are due, in my opinion, to the

slow propagation of the lesion from the mucous membrane to the uterine wall. This fact must be taken into consideration. Give the patient a short rest after the operation and then apply massage. The results will be very satisfactory.

What the action of massage in these cases was, I am unable to explain. In all probability it decreased the venous stases and increased the circulation, thus tending to re-establish normal conditions, causing granulations to disappear and inducing fatty degeneration, as was obtained by a noted Swiss surgeon, Dr. Niehaus, in Bern, in massaging granulations of tubercular nature, seated in the carpo-radial joint.

OBSERVATION IV.

Endometritis Hœmorrhagica.—Massage.—Cure.

In the month of April, 1878, there came into Dr. Pacquelin's clinic a woman, 32 years of age, complaining of profuse metrorrhagia. The first attacks came on four years ago, immediately after a confinement. The latter was, however, normal and not instrumental. Since that time the menstrual periods were of longer duration. Toward the end of 1877, by taking a rest and several months' sojourn in the country, improvement. In the intervals between the metrorrhagic periods there is a distinct sero-sanguineous discharge. Constant cephalalgia. No appetite; no movement of the bowels except by using enemata. Anæmia, general weakness. Treated with all the well known hæmostatics, but without success. The uterus is slightly enlarged and in normal position, movable in all directions. The surface is smooth, without inequalities. The introduction of the hysterometer causes a flow of blood mingled with clots of a bad odor.

It is impossible to discover a tumor as the cause of the hæmorrhage. The curette does not reveal the characteristic vegetations. On the whole the patient is in such a nervous condition that it is almost impossible to carry the examination further, so as to arrive at a proper diagnosis.

Two weeks later I again explored the uterine cavity with Sims curette. On pressing upon the fundus of the uterus through the abdominal walls, which at this time were more flabby, and on carrying the instrument into the posterior part, I succeeded in removing a small amount of vegetations. There is nothing in the remainder of the uterus. A few days later on I commenced massage. This was

rendered quite easy by the flabbiness of the abdominal walls and the patient's aid and energy, who desired by all means to be relieved from her metrorrhagia. After a month's treatment, amelioration is perceptible, she is able to spend several hours out of bed and tend to her work. Fancying that she is strong enough to take a walk, she starts out, when she is seized by profuse metrorrhagia while descending a steep incline. This imprudence retarded her cure, which lasted until July. At this time she was well, and I heard from her toward the end of the year that she was still enjoying good health.

OBSERVATION V.

Chron. Metritis.—Metrorrhagias.—Dysmenorrhœa.—Uterine Retroflexion.—Massage.—Cure.

Mrs. G., 34 years of age, dressmaker, comes in July, 1877, to the clinic of Dr. Pacquelin. Married, mother of a little girl 3 years old.

This person is a striking example of how the general state of health, although suffering from repeated and profuse metrorrhagias, may remain satisfactory as long as the digestive functions are normal.

Some months after the first delivery a second pregnancy was terminated by a miscarriage in the third month. There was an abundant loss of blood, which the physician who was called in was able to check somewhat, but not entirely. For six months the patient had to keep to her bed, losing more or less blood. Ice, tamponing with alum, perchloride or iron; impossible to entirely stop the hæmorrhage. Persistent sero-sanguineous discharge. After some time slight amelioration. But the anæmia and the weakness were so marked that she was frequently subject to syncopes and falls in the street. Pain in the back; shooting pains in the loins; frequent micturition; nervous, excitable, irascible; palpitation and dyspnœa on the slightest physical or mental exertion.

This person has gone from one hospital to another and has undergone various treatments without obtaining anything but transitory relief.

The first time I saw this patient I was struck with the relatively good state of her general health. She is pale, but she is stout, and does not seem to suffer much. And yet the menorrhagias, resp. metrorrhagias are profuse during walking and even while at rest. She tries her best to take care of her household. Uterus somewhat soft and in retroflexion; quite movable, a little enlarged. Deep pressure in the left cul-de-sac gives one the sensation of a swelling. This exudate corresponds to the lower part of the broad ligament. It is rather soft to the touch, diffuse, painful on pressure, and coincides with a spot where the patient has always complained of a sharp pain. The neck large. Through its external orifice, which is dilated, there exudes, on raising the womb, and particularly on compressing it between the two hands, a great quantity of blood, somewhat pale, and mixed with small clots. Manual exploration of the external surface of the uterus,

combined with the examination of the internal surface by means of the hysterometer, did not display the presence of any fibroid tumor, as was supposed. The curette, introduced without difficulty and with great precaution, did bring out a very small fungoid mass.

Massage difficult on account of the position of the uterus and the sensitiveness of the integument of the abdomen. In the beginning, every séance followed by an abundant loss of blood. After six weeks, marked amelioration; metrorrhagias less profuse. Her strength returns. Can work better. The treatment is followed irregularly. The patient at times absents herself from two to three weeks. The amelioration does not progress regularly, either. From time to time she suffers losses of blood, but they are less abundant than formerly. At one time she considered herself quite cured, and regarded the last loss of blood as the regular and normal discharge of the menstrual period. After four weeks' treatment by massage the above mentioned tumefaction disappeared.

For eight months after the treatment all went well. The patient was always pale, but toward the end she felt pretty well. She does not suffer from any metrorrhagia since the end of treatment, which had lasted about 8 weeks. Menstruation occurs at regular intervals, only the last two are behind time. She believes herself to be in the family way. Pregnancy terminated by normal delivery without an unusual loss of blood. Nevertheless her convalescence is slow. She complains of uneasiness in the abdomen and difficulty in walking. On examination I find an incomplete involution of the uterus. Massage for two weeks corrects all. Retroflexion still remains. Length of uterus 7 cm., of normal consistency. I heard from this patient, more than two years afterward, that she had been well during all that time.

OBSERVATION VI.

Hæmorrhagic Endometritis. — Curettage of the Uterus Without Result. — Retroflexion of the Uterus.—Massage.—Cure.

Mrs. C., 28 years of age, the wife of a baker. Menstruated the first time at the age of 16. In the spring of 1875 a miscarriage, soon followed by another. Since then a painful sensation of pressure in the perineal region, rendering walking difficult. From time to time she has slight pains in the back. Lately the monthly periods are more profuse than they were formerly. In July, 1876, while washing some linen, a violent hæmorrhage set in and persisted so that it became necessary to tampon the vagina. She also took some ergot and acetate of lead.

Compresses of cold water over the lower part of the abdomen; vaginal injections of decoctions of oak bark. When these injections yielded no result, solutions of perchloride of iron were resorted to. These remedies had but a purely palliative result. The next year, curettage of the uterus, followed by chromic acid cauterizations.

The operation was somewhat painful and did not relieve her much.

The losses of blood were a little diminished toward the end of March, when they reappeared without any known cause and with their former intensity.

Curettage in April, followed by pains and sensitiveness on the left side of the abdomen. Patient was obliged to remain in bed for three weeks. During this interval the loss of blood was insignificant; and it continued to be so up to the end of May. Under the influence of a violent emotion the hæmorrhages set in as severe as ever.

I saw this patient toward the end of August, 1877. At this time the patient presented a sad aspect. Metrorrhagia, profuse, constant; anæmia, extreme. The injections produced but a temporary hæmostasis. The uterus is large, somewhat sensitive to the touch, movable. Its external surface does not seem to present any unevenness. The cul-de-sacs are free, except posteriorly to the left, at the point of insertion of the vaginal wall. At this point there is a focus of induration of the size of a hazel nut. This is slightly painful on pressure.[1]

The hysterometer is easily introduced into the uterine cavity, which measures more than 7 cm. The diagnosis of hæmorrhagic endometritis having been made by two eminent specialists, it seemed futile for me to resort to the curette again to confirm the diagnosis. After a week's rest, massage of the uterus. This is difficult on account of the retroflexion. The results obtained during the first weeks were insignificant; later on, improvement. At the beginning of November, after nine weeks' treatment, the metrorrhagias have completely ceased. Diminution in the size of the uterus; greater consistency than at the beginning. Under the influence of tonic and restorative medications, her strength returns. At the end of five months her condition is as good as can be expected. She has remained well.

OBSERVATION VII.

Endometritis Hæmorrhagica. — Curettage. — Cauterizations with Silver Nitrate; No Result.—Massage.—Improvement.

Mrs. L., 33 years of age, of a very weak constitution. Began to menstruate at the age of 14. Every period lasted seven days. Three pregnancies terminated at full term; the last in 1872. It was complicated by violent pain in the left inguinal region. Extreme sensitiveness in this region. The patient is obliged to remain in bed for three weeks. Two months after this pregnancy she menstruated. Duration same as formerly. Amount of blood lost normal. Four months later (the patient is quite certain about the date) menstruation assumes a different character. Nothing abnormal during the following menstrual periods. No uterine catarrh. At the same time, frequent desires at micturition, palpitations, cardialgia and other nervous symptoms.

In June, 1873, in the course of her menstruation, menorrhagia. Up to 1879 frequent metrorrhagias. Losses of blood almost constant.

[1]After six weeks' treatment of this induration, all disappeared.

Subcutaneous injections of ergot without result. Direct applications of silver nitrate to the uterine mucous membrane. For this purpose preliminary dilatation of the cervix with prepared sponges. Every séance of curettage was accompanied by great pain, but only transitory improvement was obtained. Chromic acid cauterizations every six weeks, repeated for several months, were followed by extreme abdominal pain. These are followed by marked improvement, so that the patient considers herself cured. The hæmorrhages reappeared four months after the last séance, when they assumed their former character. For five months the loss continues; the patient is unable to leave her bed; she is extremely anæmic. She can hardly change her position. Every attempt to move is followed by a profuse hæmorrhage and the painful expulsion of clots of blood, which become more and more light in color. Exhaustion extreme. Uterus enlarged (with the hysterometer, 7½ cm.); slightly pushed to the right, rather more than normally. The presence of a small band which is recognized on palpating the left lateral pocket does not seem to impair its mobility. The sound moves freely in its cavity. The latter is large and the walls seem smooth along their surface. The curette reveals nothing. In spite of all this, I still believe to have to deal with fungous growths, although they are difficult to reach. To these supposed growths I attribute the rebellious metrorrhagias. After having allowed two weeks' rest to this patient, I again took up my examinations. But I did not succeed any better this time than before. I could not find anything characteristic of fungous growths (fungous endometritis). Massage was very difficult on account of the tenderness of the abdominal wall. Still, thanks to the strength and good will of the patient, I was able to carry it out properly. Improvement was quite noticeable at the end of two months, when the patient was seized by an acute bronchitis. This compelled us to stop treatment for three weeks. The patient remained in bed and lost very little blood in the interval. When her bronchitis was better I recommenced massage. Menstruation is gradually resuming its regular course. The band above spoken of has entirely disappeared through a special massage. She only complains of slight weakness; still, in spite of this, she is able to tend to her household. I saw her in December, 1877, and found her in good health.

OBSERVATION VIII.

Endometritis Hæmorrhagica.—Injections of Perchloride of Iron.—Failure.—Retroflexion.—Massage.—Improvement.

Mrs. M., 34 years of age, very robust, of a very sensitive nature, complains of having experienced, at different times, indefinite nervous phenomena. Menstruation regular and of four days' duration. In two years thrice pregnant; each pregnancy terminated in a miscarriage during the third month. Each accident was accompanied by profuse metrorrhagia, which left her extremely feeble. The last miscarriage (January, 1876) provoked an alarming hæmorrhage, as the result of

which the patient was obliged to remain in bed for over a month. Since then her menstrual periods have been longer; in fact, they have never entirely stopped; in the interval a sero-sanguinous flow continues. According to the patient's own words, "she was constantly bathing in blood." It is difficult for her to know when she is unwell and when not. Since a few months she is confined to her bed. Every attempt she makes at rising is followed by syncope and vomiting. In spite of all, her general health has not suffered to any alarming degree. Appetite is good; the patient is still quite stout. Nearly all the known astringents have been used. Even intrauterine applications of perchloride of iron have been employed, after preliminary dilatation of the cervix with prepared sponges. This treatment was followed by transitory improvement. The first periods were somewhat less profuse than the former ones. When I saw the patient for the first time, in March, 1877, she was very weak and of a waxy pallor; she lost a great quantity of blood, mingled with clots. These, after remaining for some time in the uterine cavity, presented a marked fœtid odor. She complains of an almost constant sharp pain in the left iliac fossa.

The uterus is found very movable, in retroflexion and enlarged. Its consistency is normal; its external surface entirely smooth; the external cervical orifice is quite patent. In introducing the curette into the cavity of the uterus, one gets the sensation of a soft surface, slightly resistant, but the characteristic fungoid masses are not obtained. Slight sanguinous discharge follows. For the moment I believe to be unable to apply massage in such unsatisfactory conditions to obtain any results, on account of the thickness of the abdominal wall and the uterine deviation. In fact, during the first three weeks' treatment I obtain absolutely nothing. Metrorrhagia is so profuse that in order to perform massage I am obliged as a preliminary to resort to very hot injections. I always succeeded in momentarily stopping the flow of blood by this means. After a little while the improvement of the patient's general condition is apparent; and toward the middle of June, i. e., after ten weeks' treatment, I am in the position to allow the patient to get up and take a few steps. She loses but a trifle of blood. Since then menstruation is regular.

Six months after the end of treatment her general condition is excellent, and the patient no longer has any complaint. On examination I find the uterus apparently smaller in size than before treatment was begun. Retroflexion still present.

In December, 1877, I was called to this patient again. The last period (menstrual) lasted two or three days longer than the preceding one. At the time when I saw her she had a hæmorrhage, not very profuse, which had lasted for twelve days. I employ the same procedure as before, namely, hot injections, and the hæmorrhage ceases at the end of three days, but only for a moment. Being persuaded that I have to deal with a recurrence, I resort to the same manipulations. Metrorrhagia ceases. When the menses appear again they are normal. Treatment is continued for three weeks. I saw the patient at the

beginning of the year 1880; she has lost no more blood outside of her menstrual periods.

OBSERVATION IX.

Endometritis Hœmorrhagica.—Dysmenorrhœa.—Massage of the Uterus.—Almost Complete Cure.

Mrs. G., 26 years of age, forelady in a hosiery.[1] Regular habits. Her menstruations, abundant at their first appearance, soon became profuse. In June, 1875, a miscarriage in the third month, marked metrorrhagia. Lately, moderate sanguineous discharge, constant, lasting during the entire menstrual period. Upon the advice of a midwife she took ergot internally, used vaginal douches of tannin solutions and ice cold water alternately. Improvement of short duration.

In February, 1876, patient was extremely anæmic. Metrorrhagia is lately accompanied by such violent pains that she is constantly obliged to remain in bed. In spite of all, she has not fallen away so much. This is probably because her appetite has remained good and her digestive organs as well.

On examination of the internal genital organs the uterus is found a trifle larger than normally and round in shape. It presents neither prominences nor indurations on its outer or inner surfaces; slight retroversion; its consistency is a little softer than normally. The tip of the index finger just reaches the internal orifice of the cervix. Dr. Péan introduced with difficulty Sims' curette and was able to move it about in the uterus in all directions. In pushing the curette toward the fundus and scraping it thoroughly he brought out a small quantity of soft tissue. This was, however, too small to allow a microscopical examination, and consequently he could not venture a positive diagnosis of "fungoid endometritis."

Massage seemed to me indicated. Its execution is difficult on account of the corpulency of the patient. The abdominal wall, in spite of its flabbiness, presents such a thickness as to render the fundus of the uterus difficultly accessible from this route. Still, after three weeks' treatment, marked improvement was produced. The amount of blood lost at the menstrual periods is less than before. In the interval the discharge gets less and less, and the uterus diminishes in size. Patient almost completely cured at the end of two months' treatment. The last menstruation was normal. The patient informs me ten months after the cessation of the treatment that she is feeling very well.

Sterility.

Sterility is not an uncommon symptom in chronic affections of the uterus. According to the statistics of Grünewaldt, out of 56 women affected with chronic

[1] This was the first patient recommended to me by Dr. Péan at the St. Louis Hospital clinic.

metritis he found it present in 46.4 per cent. of the cases. There are many causes of sterility. Before discussing the treatment of sterility by massage, we must exclude the congenital variety, which is not amenable to treatment, and then we only have to discuss the acquired form. Sterility results if any of the genital organs are incapable of performing their functions. It is not in itself a disease, but only a symptom of different diseases of the generative organs. We must now ascertain the seat of this disease and its nature. The most frequent cause of sterility is chronic metritis, especially the accompanying endometritis. This alone interests us here.

The following causes of sterility have been much spoken of:

First—Hypersecretion of the mucous membrane, causing occlusion of the cervical canal with a mucous plug which prevents the entrance of the spermatozoa.

Second—Acid and fetid secretion which inhibits their action on the ovum.

Third—Marked atresia of the cervix, which constitutes a mechanical obstacle.

The first cause needs no explanation. It can readily be imagined that a mucous plug temporarily prevents conception, but it will not be permanent.

I only speak of sterility in those women who are in the active sexual period of life and desire children, when at least three years have elapsed since their last confinement.

The influence of the character of the secretions has not been well investigated. Conception has occurred

when cancer of the uterus with fetid discharge was present. Such a discharge ought to be more harmful to spermatozoa than a common catarrhal secretion. There remains for discussion in this connection now only atresia of the cervix. Owing to the influence of Sims' ideas, the importance attached to this has been exaggerated. Many facts contributed to this error. Discision of the cervix caused some of the symptoms complained of to disappear, and made the patients fertile. In the great majority of these cases, atresia had been the result of cauterizations. You encounter a vicious circle which is met with at every step, in discussing uterine pathology. The mucopurulent secretion is very abundant, fills the cavity, distends the walls, and increases the venous stasis. The more catarrhal secretion there is, the more pronounced this symptom. The secretion in the uterine canal increases each day, distends the walls and makes them proportionately thinner. When an outlet for drainage is made, some of these factors disappear and the local bleeding caused by the operation likewise diminishes the passive congestion, at least for some time. It is in this manner that discision of the cervix can be efficacious in the treatment of acquired sterility, the same as, as we shall see later on, in dysmenorrhœe—although here only very transitorily.

Lott has shown, many years ago, that the spermatozoa leave the vagina by reason of their own mobility. Cases have been described in which fecundation occurred in spite of obstacles more serious than atresia of the cervix. A patient of Scanzoni, who had a polyp protruding from the cervix, became pregnant seven times. All

her pregnancies terminated in abortions. The inflammation and metrorrhagia were the cause of the abortions. The same author cites a case of irreducible anteversion, with hypertrophy of the entire uterus and elongation of the vaginal portion of the cervix, into which he was unable to introduce a fine sound. This malposition was accompanied by marked dysmenorrhœa. The patient became pregnant ten years after marriage, and her pregnancy went to full term. The author saw this patient subsequently, and her malposition had not changed.[1] It is impossible to suppose that the displacement was the cause of the continued sterility. Under the influence of treatment her general condition improved, the uterine mucosa became modified and conception became possible.

I do not believe that displacements, changes in shape, and atresia are insurmountable obstacles to impregnation. If the orifice is sufficiently large for the passage of the menstrual blood, the spermatozoa can also enter the uterus.

Does the fecundated ovum develop? Does pregnancy go to full term? That is another question. Scanzoni's patient who became pregnant seven times had seven miscarriages. These were caused not so much by the presence of the polyp as by the accompanying metritis (endometritis). Whatever the location may be, it always brings about structural changes in the mucous membrane. Fixation and development of the ovum are impos-

[1] M. Sims' Lehre von den Ursachen und der Behandlung der Sterilität. Beitr. zur Geburtsh. u. Gynäkolog. Bd 1, H ft. 1870 p. 109 and following.

sible. The catarrhal secretion and the metrorrhagia render its expulsion easy. Klebs has also observed that chronic inflammations terminate in atrophy of the mucous membrane and cystic degeneration of its glands.[1] Schröder, on closer observation, states that the ciliated epithelium is exfoliated and disappears, and is replaced by a thin layer of stratified epithelium covering the connective tissue, in which the glands have disappeared. This is all that remains of the mucous membrane of the body[2].

"We must admit," said Grünewaldt, in a work on sterility, "that the inflammatory process does exert a deleterious influence upon the ability of the ovum to become fixed, and as we recall our clinical experiences we must believe that this occurs before complete atrophy of the mucosa takes place. The elements of the inflamed mucosa act with reference to the ovum as if they were already atrophied."[3] We share this opinion. When the disease has produced the lesions indicated by Klebs and Schröder, sterility is permanent. It is then useless to try massage or any other treatment. Function cannot be restored in tissues which have become prematurely aged. These terminations are rather rare.

In one case a patient 40 years of age, with retroflexion, suffered from metrorrhagia, violent dysmenorrhœa and dyspareunia. She had been married at the age of 31, and became pregnant the following year. Her

---

[1] Hanbuch der Path. Anat. IV, Lf. II Berlin, 1873, p. 857.

[2] In Ziemssen's Handb. der Speciellen Pathologie und Therapie, Bd., pp. 121, 122.

[3] Ueber die Sterilität. Archiv. für Gynäkologie. VIII Bd. 1875.

pregnancy terminated in an abortion. This patient for a long time despaired of ever having a child. She tried massage, after many other methods of treatment had been resorted to in vain, hoping that this would stop her uterine flowing and painful menstruation. The result hoped for was obtained. Moreover, she conceived during the course of the treatment, and gave birth to a living child at full term. It is impossible not to conclude that in her case an uterine inflammation had caused the above mentioned structural changes.

If now we review what we have so far observed, we shall find that sterility is very often due to chronic inflammation of the uterus. The secondary symptoms, such as displacements, changes in shape, and atresia, are insufficient to cause it. It is due to structural changes resulting from passive congestion, which prevents fixation and development of the ovum. Its expulsion before term is favored by excessive secretion and metrorrhagia.

Massage is indicated and is successful in such cases, which may be inferred by referring to the cases in which leucorrhœa and sterility were the only symptoms. Similar good results were obtained in other cases which I shall later discuss, because flexions and versions were also present. My cases include a large number of patients in whom conception had appeared to be impossible for more than three years. Several became pregnant and went to full term. What is more, some became pregnant within three months after the treatment had been stopped—twice even before the treatment was finished. M. Asp had similar experiences. He applied mas-

sage in a young and emaciated woman who had been married for two years and had aborted several times. She became pregnant during the course of the treatment, went to full term, and was delivered of a healthy living girl. The same author mentions two similar cases occurring in his practice.

OBSERVATION X.

Chron. Metritis.—Leucorrhœa.—Pains in Various Parts of the Body.—No Pregnancy Since Four Years.—Massage.—Cure.—Pregnant Some Time After End of Treatment.

Mrs. M., 26 years of age, had a miscarriage in the second month of a pregnancy. Pregnant again in February, 1873 (pregnancy terminated at full term; boy died shortly afterward). Not pregnant in the next four years. Since her last confinement, pretty pronounced pains, so that she is unable to tend to her household as she would like to. Dull lumbar pain, accompanied by weakness all over the body, especially in her legs. Palpitation of the heart, shortness of breath. From time to time, especially at the time of her menstruation, pains in the left side of the chest, accompanied by distension of the stomach. Has always suffered from leucorrhœa ever since she began to menstruate; but lately this symptom has markedly increased, at the same time the discharge has become thicker.

Her general appearance is satisfactory. The patient wears an abdominal bandage, which permits her to walk without much difficulty. No other treatment except vaginal injections of alum solution and vaginal tampons of various medications. She came to the St. Louis Hospital clinic in December, 1877. The uterus was found in a normal position, but softer and also larger than normally. On account of the flabbiness of the abdominal walls, massage is easy. As a result of this treatment the pains diminish at the menstrual periods and during their interval; leucorrhœa has diminished; she only complains of a slight whitish discharge. At the end of a few weeks the patient considers herself well enough to interrupt the treatment. I did not see her again until the end of 1878. Since she was massaged, menstruation had always been regular. For the last three months she has not menstruated. She experiences the same symptoms as she did with her former pregnancy. From later advices I am informed that her pregnancy took a natural course and went to full term. She gave birth to a healthy girl, which is still living. The pain in the left side has entirely disappeared. I have not heard from this patient since.

OBSERVATION X.

Chron. Metritis.—Anteflexion of Uterus.—Ulceration of the Cervix.—Sterility.—Uterine Massage.—Disappearance of the Affection.—Pregnancy Followed by Full Term Delivery.

Mrs. N., 32 years of age, consulted me in January, 1885, to be treated for chronic sciatica. She was cured after 2½ months' treatment. At this time she complained of symptoms of a different nature which have troubled her since her only confinement, eight years ago. Menstruation regular, loses very little blood. Since several months leucorrhœa, discoloring the linen a greenish yellow; extreme weakness; sensation of pressure in the lower part of the abdomen; pains in the renal regions, frequent desires at micturition. Menstruation lasts eight days instead of five, and reappears every three weeks; is more abundant than formerly. Having applied to a midwife, the latter prescribed a pessary for her and made her take a purgative three days before and three days after menstruation. This treatment produced absolutely no comfort or relief. She then submitted, upon the advice of a doctor, to hydrotherapeutic treatment.

A few weeks after the end of the treatment she felt well and strong enough to enter upon a position in a mercantile house. But as this position exacted long hours, during which she had to be on her feet, it did not last long before she had a relapse of her former condition. In April I examined the condition of the uterus and its adnexa, and I found an anteflexion with slight sensitiveness on pressure; the uterus enlarged, movable in all directions; an old laceration of the cervix, an ulceration in the posterior lip. Uterine massage.

The abdominal wall is so sensitive to pressure that in spite of the favorable position of the uterus I am obliged to spend ten days in massage before I am able to grasp the uterus. The patient follows the treatment for two months and a half, with some temporary interruptions. At the end of this time she feels so well as to give up treatment entirely. The uterus is markedly diminished in size, 7 cm.; anteflexion seems now more marked than before. Leucorrhœa has to certain degree diminished; no sensation of pressure in the lower part of the abdomen, nor in the small of the back. The patient feels stronger and is able to walk without fatiguing. In April she became pregnant. The pregnancy followed its regular course and terminated at full term. No further news from her.

OBSERVATION XI.

Chron. Metritis.—Retroflexion of Uterus.—Excoriation of the Cervix.—Violent Hypogastric Pains.—Menorrhagias.—No Pregnancy Since Three Years.—Massage.—Cure.—Pregnancy Three Months After Conclusion of Treatment.

Mrs. B., 23 years of age, of a weak constitution. In spite of the constant pains she has suffered since the time her only child (a boy,

now 3 years of age) was born, she desires to have a daughter. In spite of the short distance of her home from Mr. Pacquelin's clinic, she is obliged to rest several times on the way. It is only through her exceptional will power that she is able to walk. The painful sensations consist, above all, in severe hypogastric pressure downwards, and in pains of the back, aggravated at the time of menstruation. She instinctively presses her hands on the hypogastric region and compresses it firmly. In this way she obtains slight relief.

Menstruation, already abundant, is to-day more so than it was previously; it is irregular in quantity and time of appearance, sometimes it remains away for two consecutive periods.

Appetite, poor; constipation, habitual; without rectal injections the patient would have but two or three evacuations of the bowels a week. Various treatments, resumed several times, produced but a transitory improvement.

Abdominal bandage; this she could not bear, on account of the hyperæsthesia of the skin. Vaginal injections of oak bark decoctions. Application of a pessary by a midwife. A doctor cauterized the cervix and made intra-uterine douches of perchloride of iron solutions. This medication was each time followed by violent intra-abdominal pains. Another doctor consulted by the patient cauterized the cervix with a red hot iron, and he did this several times in the course of several months. Transitory improvement.

I saw this patient the first time in July, 1878. On making a vaginal examination I find the uterus enlarged, retroflexed, movable in all directions. There is a spot in the left cul-de-sac more resisting than elsewhere. Pressure on this spot elicits quite a pain. Excoriations on the anterior lip of the cervix.

The patient wears a Hodge's pessary, which I remove at once. The flabbiness of the abdominal wall renders massage easy, but the patient, who is greatly weakened and very nervous, bears it poorly. She decides to submit to this treatment only after repeated encouragements on the part of various patients in whom the method had produced a rapid improvement. In order to avoid threatening attacks of syncope in the first few séances, it is necessary to give her a little whiskey. At the end of three weeks her strength has increased, and she now bears the manipulations very well. Her appetite, which in the beginning of the treatment was very poor, is now excellent. In fact, at times it seems exaggerated. Sleep is good; dysmenorrhœa gone; experiences no more pain since her first menstrual period.

The treatment is stopped at the end of thirty-eight days. Her general condition has completely changed. Uterus of normal size; no indurated area. Complexion rosy, eyes bright and clear, tissues firm; no more constipation; is able to take long walks without fatigue or weakness.

I have seen this patient twice since, the first time five weeks after the cessation of treatment. She was then feeling very well. The second time seven months later, in the country; she was then four months

pregnant. She did not carry the child to full term on account of her own imprudence; the patient went to a country dance. The next day a miscarriage followed, complicated by pelvic peritonitis, which obliged the patient to remain in bed for several weeks. She recovered. I have not heard from her since.

OBSERVATION XII.

Chron. Metritis.—Retroflexion of the Uterus.—Miscarriage Two Months After Her Marriage.—Not Pregnant for Seven Years.—Leucorrhœa.—Violent Hypogastric Pains.—Amputation of the Cervix Futile.—Massage.—Disappearance of Symptoms.—Pregnancy Two Months After End of Treatment.

During my sojourn at Ragatz in 1881 I had the opportunity to see Mrs. S., 32 years of age. She began to menstruate at the age of 13, and was always regular up to the time of her marriage, in 1878. No dysmenorrhœa. The flow was abundant, and lasted usually from six to eight days. A miscarriage two months after marriage; she did not stay in bed; she even continued her housework as usual. To-day her chief complaint is a slight whitish discharge and a sharp pain in the interval between two menstrual periods. (This pain has greatly diminished since.) The pain is dull in character, distributed over the entire lower part of the abdomen and the perineal regions. She can hardly sit for any length of time, so painful is the sensation of perineal pressure. The abdominal walls are painful to pressure. Constipation, stubborn. She regrets very much not to have any children. She was treated for several months by a specialist in a Swiss hospital, but without any result.

At the time when I saw her for the first time the leucorrhœa had greatly diminished; she noticed only slight discharge before and after menstruation, but the other symptoms existed in the same degree as before. The uterus is enlarged (exceeds 7 cm. in length), of a soft consistency, retroflexed, very movable; the displacement seems on one day more marked than on some other day. Nothing abnormal in the culs-de-sac. Massage is difficult on account of the extreme sensibility of the patient.

On some days I succeeded in grasping the uterus through the abdominal wall, but on others I had to give it up. After eight weeks' irregular treatment, the patient told me that it was impossible for her to continue longer. In spite of all, her condition got better. Uterus smaller in size and harder. The following year I learned that she had become pregnant two months after the end of treatment. Accouchement normal. Since then she has had symptoms referable to the right ovary, ovaritis et periovaritis, on account of which I had to treat her again in 1883. She was freed from it at the end of five weeks. For several summers, whenever I stopped at Ragatz, I saw this patient. She has remained well.

Irritations of the bladder are very common in cases of chronic metritis, whether complicated with retroflexion (version) or anteflexion (version) or not.

I am surprised to see how so many gynecologists and still more general practitioners adhere to the old theory that these affections are due to a mechanical cause arising from the malposition (flexion), from the tension of the neck of the bladder or pressure upon the cervix on the part of the retroflected uterus, while in case of anteflexion they believe that the vesical tenesmus depends upon the pressure of the fundus on the bladder, all the more when the angle of flexion is very acute and consequently the fundus, pressing more forwards and downwards, the bowels increasing this pressure, prevents the bladder from expanding normally.

He, more than any one else, who applies massage in the treatment for diseases of women, will be able to demonstrate how erroneous this theory is and show that the real cause of the irritation is due to the inflammatory state of the uterus or its surroundings. How many cases of vesical tenesmus due to this cause have not been cured, because the original affection was not revealed.

OBSERVATION XIII.

Chron. Metritis.—Anteversion of the Uterus.—Pains in Different Parts of the Body.—Dysuria and Frequent Desires at Micturition.—Massage.—Improvement.

Mrs. A., 30 years of age, entered the Hospital St. Louis in the month of March, 1876, under the service of Dr. Péan, who had the kindness of intrusting her to my care. This patient complains, above all, of frequent desires at micturition. This symptom developed a short time after her last confinement, three years ago. She urinates as often as 25 times during the day, 4 to 5 times during night. Every time

she passes but a few drops of clear urine. Most frequently micturition is slow; at other times, especially at the time of menstruation, this symptom presents a marked exacerbation and is accompanied by a burning sensation. These attacks annoy the patient greatly in her calling (she is a laundress). All physicians whom she consulted treated her for cystitis. She has taken internally balsams, Vichy and Contrexéville waters: lately she has used belladonna suppositories, but without result. The last remedy has, however, diminished the frequency of micturition by day and night. But the moment treatment was stopped the symptoms reappeared with former intensity. Furthermore, she complained of slight pains in the lumbar regions; sensation of pressure in the lower part of the abdomen; slight leucorrhœa at the approach of menstruation. She experiences now a certain difficulty in keeping on her feet for any length of time. The frequency of micturition and irregular sleep, interrupted at frequent intervals in the course of the night, have greatly contributed to this.

On local examination the uterus is found in a position of anteversion. It is firm, movable and slightly increased in size; anterior and posterior culs-de-sac free from adhesions; the urine contains no pus.

Inasmuch as the treatment, directed up to this time to the bladder, produced no improvement, and as the symptoms referable to the uterus could be held responsible for her trouble, massage seemed to me indicated. At the end of five weeks the desires at micturition are less frequent than before. After 2½ months and 46 séances of massage,[1] the irritability has markedly diminished; she is no longer obliged to get up during the night, and passes her water but 5 or 6 times during the day. In consequence of this her general condition has improved. Uterus of normal size and consistency. The patient presented herself again at the clinic on June 4, 1878. She was then doing well, and I was informed by one of her friends six months later that improvement had kept up.

Here is the proper place, I think, to speak of a symptom frequently present in chronic metritis as well as in other pelvic diseases, namely, *Constipation*, especially as the sufferers from this most annoying symptom are often relieved by gynecological massage. I have frequently discussed its etiology in my works on affections of the female genital organs. It has been asserted that it is due to mechanical difficulties. The uterus

[1]Treatment was carried out very irregularly. She came to the clinic of St. Louis Hospital in November, 1877.

drawn backward, compressed the wall of the rectum, diminishing its lumen, and when once fixed in this position the stenosis, formerly only temporary, became permanent. On the other hand, some patients whose uteri are in normal positions, or in anteflexion or anteversion, suffer from obstinate constipation. It cannot then be due to the compression and of mechanical origin. Other cases whose uteri are in positions of typical retroflexion, where the rectum is compressed, have regular movements, in spite of the stenosis. Only one conclusion can be drawn from this. Too much stress has been placed upon mechanical causes. Constipation, complicating a chronic metritis, with or without deviations of the uterus, or adhesions of whatever direction, is due to atony of the muscular fibres of the rectum. This explanation applies better to utero-rectal adhesions than to any others. It is not even necessary in such cases to speak of reflex symptoms. The inflammatory process has given rise to adhesions, and perhaps has invaded the wall of the rectum and caused an infiltration, which diminishes the contractile power. There are two varieties of constipation in pelvic affections; the one, reflex, may be observed even where the wall of the rectum is not involved; the other when there is inflammatory infiltration of the rectal wall and a partial degeneration of its contractile elements. If it is true that the results obtained by treatment indicate their real causes, then our hypothesis is confirmed. Constipation is frequently completely, sometimes rapidly, relieved by massage; this sometimes occurs so quickly as to surprise the patients.

Now, when we have to deal with a parenchymatous metritis, or a parametritis, with adhesions on either side but not posteriorly, or a perimetritis with adhesions in front or in the cavity of the pelvis, we never touch the rectum. There is no reason to suppose that because we have relieved the infiltration we have caused the disappearance of the stenosis, when the bowels move regularly. The bowels also become regular in unfavorable cases, as mentioned above; that is, in utero-rectal adhesions. This subjective improvement alone, which is certain to follow, is sufficient to justify the employment of massage in such cases.

Reflex symptoms are most frequent in uterine and peri-uterine affections. Here follow three cases where these symptoms were especially prominent; they also developed in organs very remote from the seat of the trouble.

OBSERVATION XIV.

Chron. Metritis.—Exaggerated Mobility of the Uterus.—Reflex Neuralgias in Different Parts of the Body.—Nervousness.—Massage.—Improvement.

Mrs. G., 34 years of age, the wife of a clerk, came to my office on January 27, 1877. The patient is tall and strong, and apparently in robust health. Last confinement, four years ago, normal; has never completely recovered, very painful sensation in the region of the kidneys and the lower part of the abdomen. She experiences from time to time a sensation of fulness in the vagina. This lady, who is working in a dry goods store, has to walk and be on her feet much of the time. At the end of a day's work she is completely exhausted.

Leucorrhœa, slight; appetite, capricious; digestion, slow; constipation, habitually obstinate, is constantly obliged to take enemata. The abdomen has a tendency to marked distention, especially toward evening. Frequent desires at micturition; lancinating pain in the anal region, radiating into the neighboring directions and rendering defecations and the sitting posture extremely painful. She is quite stout, but pale, and her muscles are flappy and weak.

Injection of decoctions of walnut tree leaves; a general tonic treatment; caustic intra-uterine injections.

Lately she has spent a few months in an hydropathic institution. She has noticed slight improvement, but this improvement is of short duration. Since three months she has relapsed into her former condition.

The first time I saw this patient she presented, among the symptoms enumerated, neuralgic symptoms referable to various parts, all more or less remote from the genital organs. She complains of palpitation of the heart and attacks of dyspnœa; the least excitement causes hysterical crying spells; her sleep is greatly disturbed, interrupted by painful dreams; she falls asleep again after long intervals. Menstruation is profuse, accompanied by very intense pain at the beginning. The patient is confined to bed throughout the menstrual period.

The uterus is slightly enlarged; the length, 7.5 cm.; it is firmer than normally, and extremely movable; one day in a position of anteflexion, the next day of retroflexion. Cervix is large, its external orifice large, but no other abnormalities.

The application of massage is somewhat difficult on account of the distended abdomen. In these conditions I have the patient come to my office at an early morning hour, when the distension is not so marked.

I had the patient assume the knee-elbow position. Tapottement in the lumbar region. In this way the uterus, which is at this moment in a position of retroflexion and quite firmly wedged in in the posterior pelvic cavity, can easily be disengaged and brought forward. Massage is applied in the ordinary way. At the end of a few weeks the sensation of pressure in the hypogastric region had markedly diminished. The patient was able to be up and about, and to tend to her affairs. After 45 séances within two months the cure was considered as complete. Menorrhagia and premenstrual leucorrhœa have ceased. She no longer complains of pain in the back, coccygodynia has almost disappeared; her general condition is much improved; her nervous attacks very slight. The only symptoms that remain are constipation and slight pain in the rectum.

Since the treatment I have several times seen the patient. Her general condition remained excellent; she had even lost her embonpoint which she had at the beginning of the treatment.

OBSERVATION XV.

Chron. Metritis.—Pains in Different Localities.—Massage.—Improvement.

Mrs. D., 27 years of age, housewife, came to the clinic of St. Louis Hospital in the middle of November, 1878. Pregnancy several months after marriage, in the month of September, 1874; abortion in the third month. Since then she has experienced incessant, violent pains between the shoulders; later on, inguinal pains, more pronounced on the left side. At the time of her menstruation, heaviness in the

hypogastric region, preventing the patient from walking and almost from being on her feet. She became pregnant; pregnancy terminated at full term, entirely normal, in the month of July, 1876. None of her former symptoms have let up. On the contrary, another symptom, more annoying than all the others, has been added, and that is a violent pain in the epigastric region, "so intense," she said, "that it seems to her as if her stomach were being torn out." In order to ease this pain she is obliged to throw herself on the floor and to firmly press her stomach with both hands. During the entire attack she utters heartrending cries. At the end of 10 or 15 minutes the attack is over, without leaving any trace except slight fatigue. During the last few months the attacks have become very frequent. There are from 3 to 4 during the day, and from time to time the patient is awakened during sleep by an attack of the same nature as the one during the day, but of less intensity. Digestion fair, meteorismus. General condition satisfactory. The physicians consulted by the patient have made various diagnoses. One has interpreted the attack as one of hepatic colic; another as an intra-thoracic affection, the precise nature of which he did not state; a third called it chronic gastralgia.

On examination of the genital organs I find no displacement of the uterus. The uterus, rather flabby, is easily movable, a little enlarged, softer than usually. I immediately begin massage. After 4 weeks' treatment its consistency is increased. The attacks are less violent; they are of shorter duration than formerly. After 7 weeks' treatment the painful attacks have not recurred since a fortnight. As to the other symptoms, they have noticeably diminished. The uterus measures less than 7 cm. in length and is harder. She presented herself again at the clinic in the middle of January, 1879. Her local as well as her general conditions remained pretty good. I heard from this patient in the middle of December of the same year, and her improvement has continued.

OBSERVATION XVI.

Chronic Metritis.—Reflex Gastralgia.—Uterine Massage.—Improvement.

Mrs. N., 27 years of age, a laundress, came to Dr. Péan's clinic for the first time in June, 1877. She was very pale and anæmic, and hau been constantly suffering for 4 or 5 years. The symptoms which most of all troubled her were gastric irritation and various phenomena which one could not attribute to her internal genital organs. Under a specialist's treatment, who attributed all symptoms to the uterus, the patient showed marked improvement as the result of his intervention. The intense pains in the back and micturition diminished very markedly; the gastric symptoms, however, which she had complained of remained. The treatment consisted of intra-uterine cauterization with chromic acid and applications of electricity, continued for 4 months. Internally the patient has taken iron, anti-spasmodics, bromide of potassium, valerian, etc. Her appetite has always been good.

The attacks of gastralgia are relatively frequent. On questioning the patient closely as to her antecedent history she remembers to have had similar attacks while a girl. The attacks were much less severe, and lasted but 2 or 3 minutes. Since a few months she is married, and since her marriage the attacks assume that violent character which they now present. Under the influence of a slight accidental cause, on the slightest excitement, nay, even without any appreciable cause, the attacks come on. In such an attack it seems to the patient as if her stomach were pressed in a vise. She screams aloud, compresses the epigastric region with her hands, or she clutches at the first solid object within reach. This always relieves her. The attack lasts from 8 to 10 minutes. After it is over there remains nothing abnormal. For several months she has had up to 2 or 3 attacks a day. The attacks always occur during the day. Leucorrhœa very slight. On local examination one can only make out retroflexion. The uterus is a little enlarged, the cervix that of a virgin. Massage is rendered easy, thanks to the flabbiness of the abdominal walls. After 2½ months' treatment, marked amelioration is obtained. The attacks are less painful, less frequent; no longer any pains in the back, nor irritation of the bladder; her present condition is excellent.

She left the clinic after the examination on May 14, 1877. I heard from this patient at the end of the same year. For 4 months she has been without any attack.

CHAPTER VI.

Chronic Metritis and Its Consequences. — Interstitial Exudation.—Venous Stasis.—Fatty Degeneration of the Muscular Fibres.—Alteration and Organization of the Exudate.—Uterine Sclerosis.—Alterations in Shape.

We shall now see how chronic inflammation influences the uterine parenchyma. However differently these authors may look upon the subject, their descriptions are strikingly uniform. Becquerel, without admitting that it is a phlegmasia, speaks of an engorgement that is soft or indurated, hypertrophic. Whatever the ideas of the time may be, these terms indicate an increase in volume, accompanied by changes in its consistency.[1] The latter correspond to stages of the disease. The anatomical researches of Scanzoni, which have been neither corroborated nor contradicted, are convincing. The first stage of chronic metritis comprises congestion, serous and sero-fibrinous infiltration. The uterus is red, its surface livid—this discoloration not being regular nor uniform. It is soft and doughy in consistency and very pliable. This flabbiness is more appreciable on pressure, and appears much softer than when normal. On cutting it no longer gives that gritty sensation, and feels as though the scalpel were entering flabby muscular tissue,

[1] Traité des maladies de l'utérus, Paris, 1859.

from which an abundance of blood and serum exudes. The cut surface shows large gaping veins irregularly dilated and unevenly distributed. At some little distance from the hyperemic areas are yellowish and almost bloodless areas. In the latter the muscular fibres are separated by an exudation of varying consistency. Some fibres appear normal, while the majority appear to have undergone fatty degeneration. Thus, from the very beginning of chronic parenchymatous metritis, the organ is increased in size and its state of consistency is lessened, provided these changes occur simultaneously in the mucous membrane and are accompanied by increased secretion and accumulation of fluid in the cavity of the uterus. It can readily be seen with what facility these changes take place. This is the stage of soft engorgement of Becquerel—of dilatation with apparent hypertrophy. What changes do the tissues or the exudate undergo? Robin has stated that the circumscribed inflammatory portions consist of a fibroplastic matrix with granulation cells. When the latter tissue retracts, it includes the normal tissue, changing the engorged area into an indurated chronic hypertrophy. Virchow has stated that certain of the elements have the property of forming tissues analogous to that in their vicinity. "These tissues," said he, "mainly belong to the connective tissues, and in consequence may be regarded as the final result of the pathological products. Just as in the beginning, the elements reproduce themselves indifferently, so the conditions may change and heterologous, or rather analogous, tissue may be pro-

duced, and ultimately an heterologus product is formed[1]."

This, then, is the way in which various authors look upon the same condition, differing only in their preconceived notions. Without any further discussion of minute details, one must admit:

First—That chronic metritis, after some time, produces the same changes as all chronic inflammations, especially those of the liver.

Second—That the transformation of the exudate results in a diminution and disappearance in the contractile elements (sclerosis). This is the hypertrophic congestion with induration of previous times.

It has not appeared to me necessary to describe a metritis of the body and also of the neck as Demarquay, Saint-Vel and others have done. We have given the reason for this above. The blood supply of the various portions of the uterus is so intimately connected that it is impossible to separate one from the other. When a disease involves one portion, it is difficult to predict whether it will remain confined to that portion or also involve the other. At one stage there is increase in size, with displacement and catarrhal leucorrhœa. On inspection with the speculum, the cervix appears uninvolved. A month or two later, if the disease has progressed and the treatment employed has been of no avail, the cervix will be found to be œdematous, the lips everted and ulcerated. This has been termed ectropion by some writers. If these changes are found it is difficult to imagine that the dis-

[1]Pathologie cellulaire, I, 333.

ease is limited to one part of the uterus. You may conclude from the course and location of the metritis that in all cases the shape of the uterus must be changed. The complete substitution of connective tissue for the muscular tissue requires five, ten, fifteen or more years. These changes can hardly occur in the wall of the uterus without changing its shape and its relation to surrounding structures. Very frequent and marked changes are *flexions*. In our cases a large number of these were present. In the statistics of M. Asp they were equally frequent.

Is it proper to classify them under the head of chronic metritis? Would it, perhaps, be more rational to regard this as the result of flexions? You might equally regard dysmenorrhœa, metrorrhagia and sterility as results of the flexion? Only recently, after careful consideration, have they been placed under their proper head. Velpeau attributed the symptoms to the changes which accompanied them. The bending of the cervix constituted an obstruction to the passage of the blood and caused the violent pains which may radiate into the hypogastric region or even further.

The question was debated in 1849, before the Academy of Medicine of Paris. Velpeau was firm in his belief. He did not attempt to explain when or how this symptom was produced, but above all he wished to have his ideas adopted so as to give proper direction to the treatment which up to that time had only been empirical. Hervez de Chégoin and Valleix supported him. Amusat and Hugier, more conservative, remarked that flexions alone

were rare, that they were nearly always accompanied by various symptoms. "And what about the general condition of the patient?" asked Baud and Gibert, referring to the doctrine which attributes these to a diathesis or cachexia. They declared that this constitutional condition was all important, and that the displacement amounted to nothing. "Treat the diathesis, without paying much attention to the rest; place the patients under proper hygienic conditions and the body and cervix will return to their former condition."

Paul Du Bois opposed their ideas in a series of articles. His influence was of great importance. He declared that the flexions had nothing to do with the health of the patient; that they were more or less present in many women, and that all their symptoms were due to the uterine catarrh. It was difficult to follow without hesitation the opinion of Velpeau. Cruveilhier had just denied the presence of flexions. That was detrimental to the traditions of medicine, for Hippocrates was the first to mention them. There is no precise and definite mathematical angle between the cervix and body of the uterus. It may vary to an extent hardly credible without interfering with its functions. Cruveilhier went further and became too bold in his assertions. Neither he nor his followers thought of two points which must be considered: (1) The direction of the body and cervix in a normal woman must be determined, (2) and it must be shown that this direction can only be changed under the influence of morbid conditions. In a critical review of the literature on this subject, M. Lacroix has concluded

that in the adult woman the canal of the uterus is straight; its axis corresponds to that of the inlet of the pelvis, the fundus pointing towards the umbilicus, the cervix pointing backward and below toward the sacro-coccygeal articulation. If, as we shall see, conditions change this direction, this rule no longer applies, but as soon as the causes cease to operate, the uterus will tend to return to its former position. There are many congenital flexions, but they are anomalies and produce few or no disturbances of function. They are exceptional and without much interest.

In 1854 M. Depaul described a more important variety from the clinical point of view. He did not confine himself to deductions made from measurements made on cadavers, but from actual observations on patients, who came to him for treatment of metrorrhagia, dysmenorrhœa, etc. Many of them had uterine flexions, but other conditions better explained their symptoms than these, for their symptoms disappeared when these conditions were relieved. "I have frequently seen," said Gosselin, "the pains disappear after the use of rest, antiphlogistics and sedatives, although the malposition persisted." In some cases, reported by Goupil, there were patients suffering from uterine or periuterine changes which, when once relieved, caused the patients to no longer suffer. During the last 30 years the pathological importance of anterior uterine deviations has been the topic of several controversies. Yet at this moment I hardly believe that there is any gynecologist who does not hold the opinion that anteflexions as well as anteversions, as

long as the uterus is movable, are to be regarded as absolutely physiological positions.

In the great majority of cases retroflexion is combined with retroversion. We claim:

First—That congenital flexions or those acquired early in life are well borne, and frequently the patients are unconscious of them.

Second—That all the symptoms attributed to retroflexions (versions) are due to the accompanying metritis.

Third—That they do not interfere with menstruation and are an insignificant obstacle to conception. As M. Pajot has remarked, they may constitute a difficulty, but are not an insurmountable obstacle.

Fourth—That there is never a diffuse chronic parenchymatous metritis from the outset; that it proceeds gradually, and an area of connective tissue is found alongside of an area of exudation. There are marked irregularities in the consistency, tonicity, and even the shape of the segments of the organ.

These considerations lead us to the following conclusion concerning the pathology: Uterine flexions are the result of chronic metritis; the symptoms which have long been attributed to these flexions are due to the metritis. Treatment ought to be wholly directed to the uterine parenchyma and the endometrium, so that the stasis and interstitial sero-fibrinous exudate disappear; so that the proper nutrition and tonicity of the uterus return and the patient cease to suffer, and remain as well during her periods as in the intervals. The leucorrhœal and bloody discharge will disappear or decrease, the patient will

often be able to conceive and go to full term. These desiderata are frequently accomplished by massage.[1]

OBSERVATION XVII.

Parenchymatous Metritis.—Uterine Anteflexion.—Reflex Diarrhœa.—Hypochondriasis.—Massage of Uterus.—Complete Cure of the Diarrhœa; Later on Melancholia.

Miss L., 32 years of age, presented herself at the St. Louis Clinic in March, 1877, complaining of a diarrhœa of three years' standing, in the beginning light, but since a short time more severe, and for which she had undergone all kinds of treatment, but without avail. Her trouble started in 1874, a short time after a miscarriage, and it is to this that the patient attributes her ailment. This supposition seems plausible, because the diarrhœa was accompanied by a number of other phenomena, which present, from a pathogenic point of view, a certain relationship of the one to the other. In the month of December, 1875, there appeared pains in the lumbar and intra-scapular regions, aggravated on walking or motion. This patient, who tended to her household, could only with difficulty do her work. At this time she also complained of pretty profuse leucorrhœal discharge, which has since continued. Her general character changed. Whereas formerly she was of a cheerful disposition, she now became downhearted. This form of hypochondria came on in attacks without any evident cause and lasted for several months. In the interval between these attacks her mental condition left nothing to be desired.

Her appetite is excellent, her general condition good, has gained quite some strength. From time to time her diarrhœa has stopped for a fortnight, when it would reappear and become so severe that the patient would have twenty liquid dejections a day. The greatest number of stools corresponds to the time of her menstruation. The diarrhœa occurs exclusively during the day. The patient sleeps well and is never obliged to get up during the night. The dejections are neither preceded nor followed by pain. At first Dr. Péan and myself supposed that her diarrhœa might be of a malarial origin, and accordingly we administered quinine sulfate. The result was a complete failure. It was evident to us then that we had to deal with a phenomenon

---

[1] I believe that massage treatment more than any other treatment is able to decide this question and reveal what really gives rise to the symptoms, the malposition of the uterus or its complicating chronic inflammations. I claim that massage is the only therapeutic measure capable of favorably influencing what I regard as the principal part of chronic metritis, namely, the affected parenchyma of the uterus.

I am very glad to add that at the end of my sojourn at the St. Louis Hospital, Dr. Péan, after having seen the results of my treatment, changed his view thus far held on this subject.

independent of the digestive apparatus or an affection of a purely nervous origin. According to the history of the case, we thought of the existence of an uterine affection and that this affection might be the cause of all.

On bimanual examination of the genital organs I found indeed anteflexion of the uterus; the uterus movable, enlarged and of a rather increased consistency; excoriation of the posterior lip of the cervix.

Massage of the uterus. The symptoms directly attributable to the chronic metritis disappeared very soon, and the attacks emanating from the digestive organs diminished almost as quickly.

After two months' treatment the patient had but four evacuations in 24 hours, and the fæces were better formed. I saw this patient a little over a year after treatment was stopped. In this interval she has had but two normal evacuations of the bowels a day. At the time of her menstruation the consistency of the fæces diminishes and the bowels move a little more frequently. Later advices have reached me that the attacks of melancholia have become more frequent and serious, so that finally she was obliged to be placed into an insane asylum.

OBSERVATION XVIII.

Parenchymatous Metritis.—Anteflexion of the Uterus.—Pains in Different Parts of the Body and Particularly Coccygodynia.—Massage of the Uterus.—Improvement.

Mrs. N., 28 years of age, bread carrier, had given birth to two children within a very short time. The first was a normal delivery; the second one, however, was a difficult labor. She became pregnant again; but this time her pregnancy was terminated by an abortion in the second month, with severe metrorrhagia. A second miscarriage she had in the course of the summer of 1874. Dating from this time her general condition became very poor. For two months she has been suffering from continuous metrorrhagia, later on from a purulent discharge tinged with blood. Among other symptoms, she complained of pain, sharp in character, in the groin, and of a bearing down sensation around the rectum, i. e., tenesmus, causing her a good deal of annoyance and frequent desires to go to stool, but without any result. In the region of the coccyx she experiences violent pains, especially when sitting down. These pains radiate principally into the groin, and are severe enough to prevent the patient from occupying the same position for any length of time. Micturition is regular and without any pain.

Her appetite is capricious. Digestion slow, with intestinal meteorism. Habitual constipation; the patient does not go to the toilet except every two days, sometimes even only every third day. For the last ten months she is obliged to give up her business. Frequent palpitations of the heart, without any heart affection. Violent intercostal neuralgia on the left side, alternating at times with neuralgia on the right side. This latter is less severe. She complains, above all,

of violent attacks of migraine occupying the left half of the head and accompanied by conjunctival injection and lachrymation. Vomiting relieves her, but only for a short time. When it is over the attacks very rapidly assume their former intensity. The attacks appear at the time of her menstruation and cease when fully established, and reappear, but with less severity than at the first time, about two days after cessation of the menses. This patient has followed no other treatment except the one recommended by a midwife, consisting in the repeated employment of injections of alum. She presents herself for the first time at the Clinic of St. Louis in November, 1877.

At this time she looks downhearted, feeble, and is subject to frequent nervous attacks. The attacks of migraine have lately increased.

Local examination reveals an anteflexion of the uterus. The uterus is large, movable in all directions, slightly sensitive on pressure. In the external orifice one perceives a discharge, rather mucous in character than purulent, and quite profuse. The length of the uterus is 7½ cm., softer than usually. After three weeks' treatment by massage she suffers less from her migraine. The first menstrual period which followed the beginning of the treatment is accompanied by a less violent attack of migraine than the preceding ones. The pains in the groins and in the rectum are less severe than formerly. At each menstruation the hemicrania diminishes and the other pains likewise. At the end of the treatment, in the month of January, 1878, there hardly remains a trace of the inguinal pain. The coccygodynia has, so to say, disappeared, and only appears when the patient resumes her seat very suddenly. Leucorrhœal discharge is still present, although less. Appetite and digestion are improved. Defecation daily. Is gaining weight. Of a more lively disposition. The uterus is firmer to the touch and principally less voluminous than at the beginning of the treatment. The attacks of migraine are so slight that she pays no more attention to them. She is enabled to resume her former occupation. I have several times heard from this patient that her improvement has kept up.

OBSERVATION XIX.

Parenchymatous Metritis. — Anteflexion. — Extreme Weakness. — Massage. — Gymnastics. — Improvement.

Mrs. N., 37 years of age, mother of three children, attributes her trouble to her last confinement, two years ago. Although this patient was apparently of rather strong constitution, she was extremely feeble and downhearted when treatment was begun. For two years she is obliged to lie down almost continually, without being able to tend to her household duties. This mode of living has been followed by mental depression, her appetite is gone, her digestion very poor; she has become anæmic and neurasthenical. She is extremely irritable, suffers a great deal from headaches, nightmares, frequent desires at micturition. The patient has not submitted to any special kind of treatment; her

family physician simply prescribed her rest and tonic treatment. Systematic bathing without success.

The patient decided to undergo massage treatment, and after having obtained the consent of her physician she presents herself in the beginning of autumn, 1875, at the Institute.

On examination I find a chronic metritis, with anteflexion, flabby muscles, great debility, so that the patient is able only with the greatest difficulty to walk around the room. Under the influence of local followed by general gymnastic treatment her condition improved so much that she considered herself completely cured at the end of four months. She feels much stronger and brighter than she felt for many years, and without the slightest trouble is able to attend to her household. Nutrition is good; her nervousness has disappeared; sleep undisturbed. Vaginal examination reveals the uterus of almost normal size and consistency. Since spring, 1877, the local condition is absolutely satisfactory.

OBSERVATION XX.

Parenchymatous Metritis.—Retroflexion of the Uterus.—Ulceration of the Cervix.—Pains in Different Parts of the Body.—Dyspareunia.—Massage.—Marked Improvement.

Mrs. P., 27 years of age, consulted me for the first time at the end of March, 1878, in the clinic of Dr. Pacquelin. For the last three years she complains of very severe pains during sexual intercourse, thus rendering married life miserable. These pains attain their maximum intensity in the vulvo-anal region; from here they radiate into the inguinal regions and as far as the precordial region. Since the beginning of these attacks intercourse is absolutely impossible. Her whole trouble started from her confinement in 1873. The patient has since that time a profuse leucorrhœa. The first menstrual periods which followed were accompanied by pain in the back, hypogastric pains, frequent desires at micturition and dysuria. There is a tendency to intestinal meteorisms. Dyspareunia has in consequence led to serious domestic difficulties. Constipation rather painful.

Cold vaginal injections, hydrotherapy, cold douches down the spine, injections of opium in solution, belladonna suppositories—all have been without effect.

Local examination. Large uterus in retroflexion, soft and movable. Around the mouth of the cervix, excoriations; slight mucous discharge, of ropy consistency. Her general condition not satisfactory; integument flabby.

Massage. At first the adhesion was massaged, later on the uterus. After nine weeks' treatment intercourse no longer painful, so that former absolute incompatibility became but relative, i. e., intercourse was no longer repugnant to her. The uterus is now less hard; at the same time somewhat diminished in size. Hardly any change in the discharge; excoriations are cured. Constipation relieved. Her

general condition has improved, from a physical as well as mental point of view. She sleeps well, has regained flesh, and her mind is of a cheerful disposition. Toward the end of 1879 I learned that her improvement had remained permanent.

OBSERVATION XXI.

Chron. Metritis.—Cystocele.—Slight Descent of the Uterus.—Uterine Retroflexion.—Leucorrhœa.—Violent Hypogastric Pains.—Accouchement Five Years Ago.—No Pregnancy Since Then.—Massage for Two Months.—Pregnancy at the End of the Treatment.—Return of Symptoms After the Confinement.—Rapid Cure After Massage.

Mrs. P., wife of a wine dealer, 34 years of age, always in good health until five years ago. She then had a normal confinement, followed by various general and local affections. Since that time she is constantly suffering. She complains of a dull pain in the hypogastric region. This is often so painful that when she sits down she is unable to remain long in that position. From time to time she has dull pains in the sacral region, more violent at the time of menstruation. Menstruation is in the beginning painful, but when once established pain ceases. Leucorrhœa which formerly was quite profuse has in the last few months markedly diminished. The patient, habitually constipated, has of late become more so. Her general condition is failing.

Appetite capricious, dyspepsia and intestinal meteorismus, her general disposition extremely irritable. As she lost her only child, she is very desirous of having another baby.

The first physician she consulted prescribed an abdominal bandage with a Hodge's pessary. Her walking became easier. Cauterizations of the cervix with silver nitrate. The patient took vaginal injections of alum, tonic preparations of iron and wine of quinine. Under the influence of cauterizations the leucorrhœal discharge disappeared very soon, but only to reappear with all the more intensity a few weeks later on, so that her general improvement was of but short duration.

I saw this patient for the first time in April, 1877, in the clinic of St. Louis Hospital. She is robust, well built and apparently endowed with much energy. On vaginal examination I find the anterior wall of the vagina flabby and relaxed, and I also find that there is a cystocele, a slight descent with retroflexion of the uterus. The organ is markedly enlarged, but of normal consistency. Posteriorly it is fixed, as though impacted, in the small pelvis. In having the patient assume the knee-elbow position and in exerting pressure on the lumbar region, one can disengage the uterus, which will then fall forward far enough to be grasped without difficulty through the abdominal wall. The cervix is enlarged and patent. By squeezing the uterus a small quantity of fluid, mucous rather than purulent in character, escapes from it. The application of massage is at first somewhat painful, but the patient, who has long been suffering, bears it well. At

the end of a few weeks distinct improvement is noticeable; she is able to walk, but it becomes difficult for her to wear the abdominal bandage, as this increases the pressure in the lower part of the abdomen. At the last menstrual period she no longer complains of dysmenorrhœa, and she is enabled to discontinue treatment toward the end of June. Two months after the beginning of treatment she considers herself cured. Appetite excellent, digestion good; still a little constipated; much less irritable than before, she now attends without difficulty to her household. On examination the uterus is found to have considerably diminished in size, but it still occupies the same malposition as formerly. There still exists a slight leucorrhœa immediately preceding menstruation.

At the same time that massage of the uterus was performed the anterior vaginal wall was also massaged. It has assumed a firmer consistency, and the cystocele has disappeared. She presented herself at the clinic in the latter part of June, 1877. On seeing this patient again, in the month of December, 1889, we observed with great satisfaction that the cure was permanent. Every trace of nervous irritability had disappeared. She has not menstruated for three months. Pregnancy took its regular course, and the patient was confined, at full term, of a well developed child.

Three weeks after her confinement she noticed a sensation of pressure in the lower part of the abdomen, which was so painful as to prevent her from walking. She came to consult me in my office. The uterus is enlarged and slightly lowered. As massage does not seem to me to be indicated, I advise the patient to take some ergot, in order to favor uterine involution, and to come back and see me in six or eight weeks. At that time she felt somewhat better, but she still complains of a sensation of pressure, very painful, in the back and the hypogastric region. The uterus is increased in size, 8 cm.; the vaginal prolapse has to a great extent reappeared as it was before the confinement. About twenty sittings of massage suffice to bring about a normal condition of the uterus and vagina. Since then I have several times received word from this patient that her improvement continued.

The study of uterine flexions has compelled us to consider those other conditions which are discussed under flexions, namely, *versions*. It would perhaps be better for us, for the sake of clearness and uniformity, to apply the term deviation exclusively to *Changes in Form*, i. e. to say, to flexions, and refer to Version and Prolapse under the heading of *Changes in Position*.

We have seen that the changes in the uterine parenchyma explain all the changes in form, viz: latero, antero- and postero-flexions. It is sufficient to consider the course and differences in the consistency of the tissue, and unnecessary to look upon its increase of weight and the neighboring organs to explain flexions. In regard to versions and prolapse, the same does not hold.[1] Strictly speaking, there is a change in the density of the uterus due to the inflammation, and this causes displacement due to the change in the centre of gravity, but this physical explanation does not account for the version. It is more easy to imagine that if the uterus descends and is thrown backward and forward, this will produce changes in the structures that support the uterus. These become relaxed, lose their elasticity, and elongate. Add to this the causes which favor displacements and compel the uterus to assume one or other direction. The inflammation of the parenchyma, which causes the venous stasis, and accompanies the passive congestion of the uterus, gives rise to structural changes which still further favor the displacement. This may at least partially contribute to the production of versions, if it only increases the size, and consequently the weight, of the organ. We shall here cite two cases in which chronic metritis was accompanied by displacement backwards. In one of them the patient had also been sterile for a period of ten years, a complication of which I also cured her.

[1]We only speak of versions, in this connection, when there are *not adhesions* at the same time, or when in consequence the uterus is freely movable, although at times, which are rare, the uterus may be wedged in the cavity of the pelvis.

OBSERVATION XXII.

Chron. Metritis (Endometritis).—Retroversio Uteri.—Leucorrhœa.—Violent Hypogastric Pains.—Coccygodynia.—Acquired Sterility.—Massage.—Improvement.

Mrs. T., portress, 38 years of age, has suffered for the last ten years of a uterine affection, which she claims dates back that far and was the result of a tedious labor. She comes to the St. Louis Hospital clinic April, 1876, and informs us that she has been treated by different physicians: pessaries, cauterizations, vaginal douches. One physician has tried everything conceivable, up to intra-uterine injections and curettage, with no or only transitory effect. Pains in the back, radiating sometimes into the thighs; sensation of hypogastric pressure; complains of a very annoying pain in the coccygeal region; sitting posture very painful. This pain sometimes radiates into the neighboring regions, into the back, the loins and the sacro-iliac joint. Generally of a dull character and constant, it from time to time assumes a more acute character, particularly during the menstrual period. Defecation very painful. Besides, the contents of the bowels cannot be completely evacuated without the help of emollient enemata. All cathartics which the patient has resorted to to combat this trouble have not produced anything but transitory amelioration. On account of these pains, and on account of becoming easily fatigued, walking has become very difficult. In the beginning, menorrhagia; at this moment, normal menstruation. Discharge of a certain quantity of muco-purulent fluid. Intestinal meteorism. Uterus very large, seems softer than usually, movable in all directions; retroversion. Owing to the long duration of the affections and to the multiplicity of the various treatments, I could not give any hope of a complete cure, so much the more as I was obliged to spend three weeks in combating her corpulency, which was troublesome to massage, and in rendering the integuments softer and more pliable.

In spite of the difficulties, and contrary to all expectations, I finally did succeed in relieving these affections.

After 46 days of treatment, followed with perfect regularity, the patient declared herself almost cured and left the clinic after having been examined by Dr. Péan. At my request she comes to see us again four months later. The coccygodynia is gone; likewise the dyspareunia; the lumbar pains and the hypogastric pressure also; can walk without any inconvenience or fatigue; has noticed but little leucorrhœal discharge after menstruation; almost daily spontaneous movements of the bowels, without any pain; uterus decreased in size, harder; still in retroversion; general appearance much better.

Four months after the treatment the menses did not appear for two periods, which had never happened to her before. The patient came to see me, quite alarmed about this. I suspected pregnancy, and apprised her of my supposition. This she refused to admit. My diagnosis was, however, sustained, and this patient was delivered of a child at full term. After that I lost sight of her.

OBSERVATION XXIII.

Chron. Metritis. — Retroversion. — Dysmenorrhœa. — Gastric Disturbances. —Gastralgia.—Cephalalgia at the Time of Menstruation.—Massage of the Uterus.—Cure.

Mrs. L., 28 years of age, an American, of a delicate constitution; menstruated for the first time at the age of 15, and since that time has always been regular; the duration is three days, but the flow is somewhat scanty. As a young girl she was very anæmic. Slight leucorrhœa before and after menstruation. Cephalalgia paroxysmal, assuming the form of migraine. After the administration of iron, slight improvement. In 1879, scarifications of the cervix and cauterization of an old ulceration of the cervix. For one whole month she rested in bed. Her general condition was satisfactory until the autumn of 1882, when she got married. A few months later, thick, yellowish-green leucorrhœa. The latter has lately diminished a good deal. Pain in the back. Her anæmia has reappeared; she is weak and downhearted. Dysmenorrhœa. The pain is quite severe, so that the patient is obliged to go to bed. It continues for six hours after the appearance of menstruation.

The patient suffered also from cramps in the stomach, especially during night, and from a pain in the left groin (ilio-inguinal neuralgia). She came to my office in the spring of 1885. On account of the extreme sensitiveness of the abdominal walls and the large amount of adipose tissue it was impossible either to palpate or examine the uterus.

Massage of the abdominal parietes. It took me 15 days to diminish the sensitiveness so that I was enabled to examine the uterus. The uterus is large, not more resisting than normally; it is retroverted, and inclines distinctly to the right; more than usually it is movable in all directions, but sensitive to pressure. In the right cul-de-sac, slight resistance, corresponding to the inner portion of the large ligament; slight pain on pressure. Treatment continues to be a difficult task. As we advance, however, the sensitiveness of the abdominal walls, as well as of the uterus, diminishes, so that toward the end the manipulations are very well tolerated.

In the course of three months I am obliged to interrupt the treatment several times on account of the patient's absence. Still, toward the end of the treatment marked improvement becomes manifest. The menstrual flow is of a brighter hue and more abundant. There is only slight leucorrhœal discharge before and after menstruation. The stomach cramps are less frequent and less painful. Her general condition is satisfactory. The only symptom she now complains of is paroxysmal headache. The uterus is diminished in size, less painful on pressure. The resistance has disappeared. Six weeks' treatment of the cephalalgia by massage cures it.

I saw this patient again in October, 1887; she complains of but slight leucorrhœal discharge and slight headaches at the beginning of menstruation. No more dysmenorrhœa or gastralgia.

I do not know whether the term cure can be applied to versions and flexions. The patients no longer have hypogastric pains or dysmenorrhœa. A number who had been childless many years became pregnant. Yet in saying that they had been cured, I am not exaggerating. However, if the pathological conditions are considered they cannot be regarded as cured. The flexions or versions, after the treatment, remained as before. I had thought at times I had obtained some improvement. Repeated examinations, however, convinced me that I was mistaken. I do not believe that simultaneous massage of the uterus and the broad and utero-sacral ligaments, as recommended by Brandt and some others, would have yielded better results. I had likewise resorted to this latter method, but without success, among others in a case of retroversion, where I thought I had obtained a complete cure. The uterus remained in its normal position for a fortnight. As soon as I stopped the treatment the retroversion recurred, owing to the pressure of the intestines. In several others the results were the same. I saw these patients several months later. The displacement was unchanged. When the uterus has been retroverted but a short time after childbirth, a permanent relief may be obtained after three or four weeks' treatment. At this time it is possible to act upon the utero-sacral ligaments and by uterine massage hasten the delayed involution.

I have not been more successful in flexions, in spite of my following Brandt's procedure very closely. In

anteflexions[1] I have at times thought I obtained some amelioration in the condition by directing the treatment to the uterine parenchyma, but the result was of short duration, just as in the versions, and the uterus was just as much anteflexed as before. Now when I have to deal with a flexion or version, I disregard these conditions, for I am convinced that these alone are unable to give any symptoms, not even constipation, when the fundus exerts pressure on the rectum.

Josephson calls attention to the frequent occurrence of uterine retroflexion due to the pressure of ovarian tumors, where absolutely no symptoms on the part of the uterus are present[2].

Prof. Salin, of Stockholm, in an article in "Hygiea," 1894, claims that he never observed any symptom-complex of importance to suddenly disappear after reposition of the uterus; the patient complained of the same symptoms, whether the uterus was resting in the pessary in ante- or in retroflexion. In not a few cases the uterus occupied an alternating position, at one time anteflexion, at another time retroflexion, and yet he never noticed that the malposition of the uterus had any effect upon the state of health of the patient. He also observed that patients who had worn a pessary on account of retroflexion, but who had for some reason or other had it removed, returned complaining of their former ailments, and still the uterus was in a position of anteflexion.

---

[1]It was at the time when I regarded anteflexion as a pathological affection.

[2]Lärobok i Gynekologi, Stockholm. 1901.

Moreover, patients declared themselves healthy and free from former symptoms, although the uterus remained in retroflexion.

If the versions and flexions do have any influence on the metritis, that influence is only produced when they increase venous stasis. Owing to the reasons given above their influence is unimportant. There is, however, an unusual unanimity of opinion among physicians regarding the importance of these conditions. General practitioners, specialists, patients, everybody, is interested in them. As soon as a version or flexion is discovered it is thought necessary to rectify and maintain it in its proper position. All kinds of pessaries have been employed, among which that of Hodge appears most in vogue. Next to this comes the abdominal binder. I do not believe that any pessary is capable of affecting an anteversion or retroversion, unless it be for a short time. For flexions there is no remedy. Many physicians erroneously believe they have a remedy for it. However, the problem is a simple mechanical one. What is required to restore the uterus to its normal position and retain it there? A fixed point of support, and sufficient power to overcome the causes which tend to displace the uterus. Not one of these conditions is fulfilled by the pessary. The pessary is only held by the vaginal muscles, whose tonicity is gradually diminished, and it becomes necessary to use larger pessaries. The organs of this region are continually subject to displacements on account of the change in volume of bladder and rectum, walking, etc. The point of fixation is very uncertain. The presence of a foreign body in a

natural cavity has other inconveniences. It provokes catarrhal secretion, with relaxation of the adjacent tissues. The patient is obliged to remove the instrument to clean it, and she replaces it as well as she can.[1] Abdominal binders are not much better. They simply press the intestinal coils up toward the epigastrium. In spite of all this, however, patients maintain that they are better, or at least have enjoyed some relief. We have no reason to doubt this. The patients desire improvement, and if any occurs we may attribute it to the partial immobilization of the uterus. The latter is inflamed and movable, and every movement they make causes pain, and rest relieves them. In this way several gynecologists of note have explained the relief obtained by the binders, even going so far as to claim immediate relief after the application of a pessary. As for myself, I have very seldom had this success. Suggestion plays, in my opinion, here, as it often does in medicine, a very prominent part, and I may not be in possession of the same suggestive power as so many others. We frequently notice that these wonderful results are of but short duration. The ideal results, or at least such approaching them, in an orthopedical respect, obtained by Alexander Adams's operation, are far from being so as regards the symptoms of retroflexion (Krönig and Feuchtwanger, Monatschr, f. Geb. and Gyn.; 1900, X. and XI.), as the conditions of the simultaneous chronic inflammation of the uterus have

[1]This inconvenience has been greatly done away with by applying hard rubber pessaries, which, with their smooth surfaces, do not undergo any change under the influence of the products of secretion and are very easy to keep clean.

only in a small degree, thanks to the improved condition of the venous circulation, or not at all been improved by the reposition of the uterus into its normal position.

In the great majority of cases, I maintain and repeat that flexions and versions do not produce any symptoms. The morbid symptoms which accompany them are due to the metritis (endometritis).[1] This is proved by their complete disappearance when the metritis is relieved. I recommend massage because it cures the latter, and the patients no longer have symptoms referable to the displacements.

---

[1] I think I have been the first one who, to my knowledge, publicly expressed this opinion, because as far back as 1875, in my first modest publication on *Massage of the Uterus*, I pronounced myself categorically in favor of the new doctrine concerning the clinical importance of retroflexio uteri.

CHAPTER VII.

Mechanism of Dysmenorrhœa.—Congestive and Mechanical Dysmenorrhœa.—Infrequency of the Latter.—Phenomena Accompanying Dysmenorrhœa.—The Effects of Massage on Chronic Metritis.

Dysmenorrhœa is of such clinical importance that I have reserved an entire chapter for its discussion. Patients most frequently consult the gynecologist on account of this symptom alone. Its disappearance means for most of them a cure. They no longer suffer during the menses, and therefore they consider themselves cured. This train of reasoning is not wrong. Dysmenorrhœa, however, is only a symptom. Its nature and cause have been much discussed. Two principal varieties have been described—an ovarian and a uterine. It is, however, often difficult to distinguish one from the other. Pains due to the metritis are often referred to the neighborhood of the ovaries, and as uterine massage relieves them, it proves that they were merely secondary. The diagnosis can only be made by exclusion. If by careful examination the uterus is found to be normal, and the above mentioned symptoms are present, they can only be attributed to ovarian trouble. We shall not discuss this question here. Primary ovarian dysmenorrhœa is rare. It is only seen in chronic ovaritis, and appears as pains in the ovary alone or radiating to the hips and thighs. Massage of the ovary

usually exerts a beneficial influence on the dysmenorrhœa, because the ovaritis is improved by it. We shall not here discuss those cases in which the dysmenorrhœa is due to changes in the tubes, peri- or parametrium, especially as these often co-exist with changes in the uterus.

Now, then, if we are dealing with uterine dysmenorrhœa, in order to determine its cause and explain its etiological factors, we must discuss several theories. It has been stated that this symptom was of nervous, congestive or mechanical origin. The distinction between neuralgic and congestive dysmenorrhœa is too subtile. There then remain for discussion the other two varieties. The supporters of the mechanical doctrine assert that the cervical canal is too narrow and retracted to permit free discharge of the menstrual blood. We have already said enough on this subject to show that their views are erroneous. Cervical stenosis would only cause difficulties at the menstrual epoch. Owing to the influence of Marion Sims this idea has for many years been very popular among physicians. The woman suffers constant dull pains in the hypogastric or lumbar region, increased on walking or movement, especially just before the menstrual epoch. The pains, at first ill defined, assume a paroxysmal character. On examination, neither version nor flexion may be discovered. There is increase in the size of the organ, and perhaps also in the density. Without doubt, the cervical canal is retracted. Discision does not always give the desired result, except that temporary relief experienced for three or four periods, which is due to relief of the congestion brought about by the

hemorrhage of the operation. The uterine pains continue to trouble the patients just as before. It is only necessary to consider these cases to learn that the mechanical theory is unsatisfactory and its applicability limited. Frequently you see patients in whom the external os is so small that it is impossible to pass the smallest uterine sound, and yet these patients have not suffered from dysmenorrhœa. There are some atresias which do require operation, but they are due to repeated cauterizations, as we have seen in some of our cases. It is inadvisable to take the exceptions for the rule and base our therapeutics on a rare accident. "The difference," says M. Gallard, "between mechanical and congestive or inflammatory dysmenorrhœa is not very distinct, from the clinical standpoint; the symptoms of the one shade insensibly into the other."[1] It is difficult to understand how these two theories can be in accord with one another. How can cervical atresia give rise to hyperemia of the mucous membrane? How can its congestion produce cervical stenosis, unless it is followed by inflammatory exudation?

Scanzoni's experiment, undertaken to disprove Marion Sims' mechanical theory of dysmenorrhœa, appears to me most instructive and convincing. In order to demonstrate that no mechanical obstacle existed to account for the dysmenorrhœa, he introduced an ordinary uterine sound, at the time when the pain was most severe, just before menstruation. Instead of meeting with resistance he was able to move it freely about, and on withdrawing the sound, not a drop of blood exuded. The sound was

[1] Leçons sur la menstruation, p. 278, Paris, 1885.

not even discolored. Consequently at that moment no blood could have accumulated in the uterine cavity. Besides, every gynecologist has noticed that frequently when the pains are very violent at the pre-menstrual period, patients are obliged to remain in bed for twenty-four to forty-eight hours, and then when the eagerly expected moment arrives and the first drops of blood appear, the pain disappears.

Congestive and mechanical dysmenorrhœa vary greatly in their frequency, the former being quite common, while the latter is much more infrequent. Dysmenorrhœa, sterility and lecucorrhœa are due to the same cause, chronic uterine inflammation. If we desire a more precise explanation for the congestive variety, the anatomical researches of Patenko furnish it. We have seen that the terminations of the nerves end in the neighborhood of the cul-de-sacs of the glands, and it is at the surface of the mucous membrane that the last part of the menstruation takes place. The expulsion of the blood and the return of the mucosa to its normal state are phenomena of organic restoration. It is hard to imagine that all this will be regular, and that the nerve endings are not in some way or other affected, when there are alternative areas of passive uterine congestion and exudation. Then the same conditions are gone through again with the same phenomena, for we have to deal with a process of great simplicity and whose results alone vary. Let us set aside stenosis. The mechanism of the dysmenorrhœa is explained by:

Irritation and compression of the nerve terminals by active menstrual congestion.

Subacute exacerbations of a chronic metritis.

We are now going to give some observations in which menstrual pain was the principal symptom.

OBSERVATION XXIV.

Chron. Metritis,—Cicatricial Atresia of the Cervix.—Marked Leucorrhœa.—Dysmenorrhœa.—Dicision of the Cervix.—Massage.—Cure.

Mrs. N. presents herself to me for the first time in March, 1878, for an atresia of the external orifice of the cervix. Such, at least, is the diagnosis made several months ago by a physician from Lille. It is to this symptom that she attributes the dysmenorrhœic symptoms she is suffering from. She was always very regular. But four years ago she became pregnant, and had a miscarriage in the fifth month. Since then, profuse purulent discharge; for eight months a midwife cauterized her with silver nitrate, but the leucorrhœa did not disappear, and her general health became worse.

Dysmenorrhœa; pains, slightly pronounced in the renal regions, but violent in the groins and lumbar region. Painful pressure in the anus; this causes the sensation as though she had to go to the closet. Her appetite poor; digestion slow; at present, in the interval between the menstrual periods, dull renal pains. If she walks on uneven ground, or if she rides in a 'bus, the pains become unbearable.

Weakness of the lower extremities. For a long time the patient has not been able to go out. She is overcome by fatigue, and is obliged to rest in bed for an hour every time she takes a walk. Her mental condition is not satisfactory; she is downhearted.

No abnormality in the position and mobility of the womb. The latter is slightly painful on pressure, the cervix is enlarged. There is a discharge of abundant glary fluid. The external orifice is slightly open, very tight, so that a fine whalebone bougie can be passed only with the greatest difficulty. The hysterometer reveals a length of more than 7 cm. We are certain that the cervical atresia, which seemed to have originated from the abuse of cauterization, is not the only cause, nay, not even the principal cause, of dysmenorrhœa.

In spite of all, bilateral incision of the cervix is indicated and executed. Hæmorrhage is pretty profuse. After making the incision an opening is obtained sufficiently large to permit the introduction of the index finger. In spite of all the precautions taken, cicatrization returns and our result is almost naught. It seems that dysmenorrhœa was markedly less in the two periods that followed our intervention, but it recurred in the following periods. Under these conditions I made up my mind to try massage, and this all the more as the

methods employed up to the present time had brought about but a temporary and insignificant improvement. At the first menstrual period which followed the beginning of the treatment, the dysmenorrhœa had already diminished to a great extent. Soon after, all the other symptoms diminished. Toward the end of July, 1879, she was completely cured, with the exception of a slight leucorrhœa. Treatment lasted nine weeks. She had in all 42 séances.

OBSERVATION XXV.

Chron. Metritis (Endometritis).—Anteflexio Uteri.—Dysmenorrhœa.—Diarrhœa at the Menstrual Periods.—Massage.—Cure.

Mrs. S., 28 years of age, native of Sweden, consults me in Paris in the month of December, 1878, on account of violent pains at the menstrual periods. In 1874 a miscarriage in the early months of pregnancy. This accident did not produce any immediate consequences. It was 4 to 5 months after this that she began to complain of pain at the approach of her menstruation. In the interval she was tormented by a dull, bearing down pain in the back, with a dragging sensation in the loins. The pains gradually increased in intensity, and were accompanied by a sensation of heaviness in the abdomen. The menses got so painful that the patient was obliged to remain on her back for 2 or 3 days. As soon as the menstrual flow comes on, the pain ceases. Her general state of health has suffered very little. The patient always presents the appearance of perfect health.

The digestive tract was not deranged till the spring of 1877. After this the menses were nearly always accompanied by a diarrhœa, which persisted until after the cessation of menstruation. No tenesmus, no colics. She sometimes has 12 liquid stools in 24 hours. The diarrhœa persists during the night. At times 2 or 3 menstrual periods pass without the occurrence of these symptoms. The patient is exhausted after each one of these attacks, but she picks up very quickly, and to such an extent that after a few days no one would surmise that anything was the matter with her. This patient has been treated with cauterizations of the neck of the uterus: sitz baths, iron and saline baths (Kreuznach); enemata of opium; suppositories of belladonna. The intestinal trouble has been treated by another physician, but he has never succeeded in stopping the diarrhœa for more than 24 hours.

When I saw this patient for the first time she had not followed any treatment for over 18 months. She has a leucorrhœa, quite insignificant; but the diarrhœa and the dysmenorrhœa are as severe as ever; the latter obliges her to stay in bed for 48 hours if she desires any relief at the time of menstruation.

Uterus enlarged in anteflexion, exerts a great deal of pressure on the bladder. The former frequent micturition no longer exists. The consistency of the organ is softer than usually and it is quite movable.

Nothing to be detected in the cul-de-sacs. The sound enters for more than 7 cm.

In the beginning, massage is painful, especially on a level with the fundus uteri; but the pain ceases almost completely after a fortnight. As in the case preceding this, the treatment was begun immediately after a menstrual period. At the next period the patient was quite surprised by the painless menstrual flow. She was standing close by the sofa, loosening her gowns in order to undergo the treatment, when she said: "I cannot understand why the blood does not come on. By this time I ought to be in bed for at least a day or two and be suffering from pains." Scarcely had she said this when she exclaimed: "Now it's coming on!" The mere thought of the painful séance which she was about to submit herself to, had probably produced sufficient mental shock to cause a rupture of the capillaries of the mucous membrane. The pain did not return during the 5 days of her menstruation; and it did not set in during the entire duration of the treatment, 8 weeks (42 séances). Diarrhœa accompanied this first and following period, but the fœcal matter was less liquid. Subsequently the diarrhœa stopped entirely. The patient feels better. No longer any sensation of heaviness in the abdomen or pains in the loins. Mental state much better. Uterus, 7 cm.; consistency increased; always in anteflexion.

I saw the patient again after the third menstruation that followed massage. There was no dysmenorrhœa, properly so called, but the patient did not feel as well as during the preceding epoch.. She complained of a sensation of uneasiness in the abdomen. Ten more séances were sufficient to cause its disappearance. Twenty-two months after the cessation of treatment I received a letter from this patient, who had returned to Sweden, in which she states that she has no more menstrual trouble or diarrhœa. Her general state of health is excellent.

OBSERVATION XXVI.

Chron. Metritis (Endometritis).—Dysmenorrhœa.—Cure.

Mrs. M., 36 years of age, came to my office in the early part of April, 1880. Mother of two children, the younger 5 years old. Menstruation at the age of 13, without any complication; always regular. The last confinement very painful and tedious. Since that time treated by different specialists for uterine catarrh with extensive ulceration. Cauterization with silver nitrate; intra-uterine injections with a solution of perchloride of iron. Hydrotherapy, salt water baths: amelioration, but latter only temporary. From time to time, especially at the time of the menses, she complains of pains in the region of the loins, radiating into the thighs. Moreover, she complains of dull pains over both ovaries. These pains assume an acute, paroxysmal character. The leucorrhœa, formerly profuse, is at present insignificant; only a slight muco-purulent discharge. Duration of the menstruation 4—5 days. No menorrhagia. The dysmenorrhœa has increased. For more than two years the patient has been obliged to stay in bed

48 hours before the onset of the menses. The pains cease as soon as the sanguineous flow is established; they reappear, but although very slight, the following day and last to the end. Digestion, poor; appetite, capricious; constipation. Great swelling of the abdomen. Uterus, voluminous, movable in all directions; marked anteflexion. Tenacious and thick mucoid fluid escapes the cervical orifice, although only in small quantities. Intestinal meteorism renders massage very difficult. Uterus a little sensitive on pressure. The manipulations are accompanied by a sensation as though traction was being exerted in the region of the heart. These remote pains are more painful than the local ones, produced by massage of the uterus proper. They cease entirely after a fortnight. The treatment was begun immediately after a menstrual period, and, what is very strange, the next menstruation came on quite suddenly, and, so to say, by surprise, as it was not preceded by any prodromata. It set in, while she was out assisting at the opening of the Salon in Paris. She was able to go out in the evening and dine without suffering any inconvenience. During the entire duration of the menstrual period, no more pain. After this she was always free from catamenial pains. No further complaints in the region of the ovaries or the loins. The patient is able to take long walks, remain standing for a long time. No leucorrhœal discharge. No constipation. The meteorism, too, is almost gone.

The treatment has lasted from 7 to 8 weeks; there have been 44 séances. The patient has gained flesh and strength, and looks quite healthy. I saw her several times during the following years. She was always enjoying good health.

OBSERVATION XXVII.

Chronic Metritis.—Violent Ovarian Pain.—Dysmenorrhœa.—Massage of the Uterus.—Cure.

Mrs. M., 23 years of age, an embroideress, claimed my services for the first time in February, 1879. She complained of violent pain in the groins, more marked on the right side. Two accouchements; the last one, four years ago. It is to this that she attributes the origin of her trouble. It was a pretty hard labor, and it was necessary to apply forceps and to introduce the hand into the uterine cavity in order to deliver the child. In spite of all this, no serious puerperal symptoms followed. The patient recovered very quickly. She began to suffer at the appearance of her first menstruation, three months after the confinement. The pain, which at first was dull in character, assumed from time to time a sharp character; the ovarian region became very sensitive on pressure. In the interval between the periods there always exists pain; but its intensity is markedly less than on the days corresponding to the menstruation. At this time she also complains of frequent micturition, accompanied by a cutting pain. There is also a point of tenderness in the left hypochondrium. Dysmenorrhœa. Tendency to flatulency. This patient possesses, in spite of all, a good con-

stitution, and has gained flesh; but the tissues are flabby, without any resistance. Since her last confinement all these symptoms have increased. Headaches dull, but pretty constant; weakness more marked than previously. Complains of great pain on walking. The jolting of a carriage causes her almost unbearable pain in the groins, so that she hesitates to leave the house. She is downhearted and weeps on the slightest provocation. The entire treatment has been, vaginal injections of oak bark decoctions, purgatives and cooling draughts of various kinds. A doctor applied electricity to the ovarian region. No treatment has yielded the slightest benefit. The length of the uterus exceeds 7 cm. Its consistency softer. The position of the organ is almost normal; it is very movable, and can be displaced in any direction by the slightest impulse. No abnormality in the peri-uterine region. We discover that at the time of menstruation, at a moment when the ovarian pain has reached its maximum, explorations of the region produce no hysterical attack. The thickness of the tissues is such that in spite of all our efforts we are unable to get at the ovary.

Under the influence of massage, applied exclusively to the uterus, a marked improvement of the symptoms experienced by the patient is obtained. It is the ovarian pain that offers the greatest tenacity and that resists the most energetic treatment. It is, however, overcome without any special treatment of the ovary, but before the patient experiences any improvement in this region it takes six weeks. The slight vaginal catarrh superimposed during the treatment is easily cured by a small tampon of alum. After 9 weeks' treatment the patient is nearly well. The uterus of almost normal consistency.

Pain in the inguinal region reappeared at the time of the last menstrual period; but it presents by no means an intensity comparable to the one at former periods. The other symptoms, equally less pronounced, are still threatening. The patient stays for 5 months with her parents in a Southern climate. She experiences slight pains in the inguinal region after her first menstruations following the treatment, but they have since entirely disappeared.

OBSERVATION XXVIII.

Chronic Metritis.—Ovarian Pains at the Time of Menstruation.—Reflex Pains in Various Parts of the Body.—Improvement.

Mrs. E., 30 years of age, has since her youth had leucorrhœa and dull pains in the groins at the time of menstruation. Since her marriage, three years ago, these symptoms have in part disappeared, and menstruation, up to this time irregular, has now become regular. She had an abortion a few months after her marriage. A short time afterwards, another pregnancy terminated the same way. The menstrual pains persist during the entire duration of the flow. When out in the open air or walking she has to urinate frequently, and she passes but a few drops of colorless urine at a time. She has a disgust for all food. During digestion, colicky pains and flatulency. In spite of all these

symptoms, the patient continues, thanks to her strong will power, to attend to her work. During the week that follows the menstrual period the ovarian pains leave her and reappear the week following for some days. They become violent when walking over rough ground or when she accidentally makes a misstep; sometimes they are so severe as to make the patient cry out. Pressure over the ovarian region elicits pain; after repeated manipulations this pain is not so great, and I am finally able to grasp the ovary. The abdomen does not appear so sensitive as before. Before the treatment she used vaginal injections of alum solutions; over the inguinal region tincture of iodine was painted, and vesicatories were applied. All these means brought about but a slight and transitory improvement.

The uterus is 7.5 cm. long; of normal consistency; the cul-de-sacs are soft.

Massage of the uterus. The first time she menstruates after treatment was started, the patient declares that her symptoms are less painful. The pain was far from being so sharp as formerly, and the patient was not obliged to go to bed, as formerly, during the entire duration of menstruation. The patient stops the treatment at the end of 7 weeks (September, 1877), in the course of which she had 44 séances of massage. The inguinal paroxysms at the time of as well as after menstruation exist no longer; she only experiences at this time a dull but easily bearable pain. Her appetite has returned; the patient is the picture of health. She is able to take walks, do her work, tend to her shopping without the slightest suffering and without getting tired. The patient's sister informed me the following year that not only had her condition remained good, but that the patient felt better than at the end of the treatment and was only seldom reminded of her former pains.

And now having briefly described the most important symptoms of chronic metritis, the question arises: *How does massage act in these cases?* It seems at first that the manipulations could not act in a proper manner upon the parenchyma through its entire thickness, especially on the deeper parts, situated in the neighborhood of the uterine cavity. The treatment seems less efficacious on these than on the superficial parts, where the manipulating hand is more directly applied. Where the uterus is more than ordinarily hard, or where it feels as if there were some deep foci of induration which some

might say are not capable of being influenced by the manipulations, the consistency of the uterus is somewhat favorably influenced by massage and becomes a little softer. If the uterus is soft, which is more common, and which is fortunately more favorable to our treatment, massage makes it firmer and more resistant. It is sometimes curious to see how in the latter condition the uterus, as it increases in consistency and diminishes in size, often becomes firm and globular like a billiard ball, with a tendency to slip away from the hand at each movement.[1]

It must be understood that massage is useless in the final stage of chronic metritis, that of sclerosis, where there is more or less complete degeneration of all the uterine elements except the connective tissue, which seems to be increased in quantity at the expense of the others. No matter how long the uterus is massaged, the degenerated elements cannot be restored to their normal condition.

The procedure causes its ordinary effects and it seems useless to describe in detail here.[2] It diminishes the stasis and increases the circulation perhaps more in the uterus than anywhere else, on account of the importance of the muscular element of which it is composed.

---

[1]I recall an instance in this connection where a surgeon at one of the hospitals in Paris, when taking hold of the fundus uteri, at first thought a woman a virgin because her uterus was so small and globular, when as a matter of fact she had been the mother of two children and had been suffering from chronic metritis, with a very large uterus, and whom I had scarcely finished massaging.

[2]See Norström: Traité Théorique et pratique du Massage, p. 34, Paris, 1882; 672 pages.

It provokes contractions of the latter. Some feel that these contractions continue for a while even after every séance of massage. Massage is doubly indicated in chronic uterine inflammations because it regulates the circulation, increases the muscular tone and causes a complete change in the nutrition of the organ, three very important elements in this process.

CHAPTER VIII.

Massage in Different Uterine Affections.—Subinvolution.—Prolapse.—Fibroids.

We have combined in this chapter a certain number of affections in which massage is useful. It is impossible to place them in the same category as those we have already discussed. In the former our position was a correct one to take; massage was efficacious; the patient's health returned, and the uterus resumed its former functions. The results have been less striking in cases we are about to describe. If you except *subinvolution* which is cured by massage, you may be able to say that even in these, massage is an excellent palliative, holding its own with the best recognized conservative measures.

One thing which is almost neglected in practice is to observe whether *involution* occurs regularly and without delay. Sometimes at the proper time this process of involution ought to be hastened. Frequently it may be possible to predict the development of a chronic metritis with its consequences, as well as posterior displacement, which constitute nearly all of the parous woman's complaints. All of these are indeed the result of delayed involution after confinements, and more frequently after miscarriages. The enlarged uterus of its own weight has a tendency to sink, and at the same time the suspensory ligaments are softened

and relaxed. Massage, at first with light friction and after a few days with heavier pressure, will increase the venous and lymphatic circulation, and consequently act favorably upon the nutrition. Organic changes occur very quickly, not only in the uterus itself, but also in the surrounding tissues. Fatty degeneration also occurs simultaneously with uterine involution. Under the influence of massage the suspensory ligaments regain their tonicity and elasticity, and thus give proper support to the uterus.

In applying massage several times a day, the uterus quickly diminishes in size and the fundus cannot be more readily seized above the pubic symphysis. After a while it diminishes to less than half its former size, and gradually returns to its normal condition.

In Case XXIX massage had been applied for the relief of metrorrhagia, the result of imperfect involution of the uterus after confinement. The recovery was rapid and complete.

OBSERVATION XXIX.

Incomplete Uterine Involution.—Ulceration of the Cervix.—Retroflexion.—Cauterization of the Neck.—Faradization of the Uterus Without Success.—Massage.—Cure.

Mrs. M., 32 years of age, housewife. Two normal confinements. In their interval other pregnancies terminated in abortions at the second month; took her a long time to recover, and had to stay in bed for a month. She became pregnant again as soon as she had recovered somewhat. The pregnancy went along without any accidents, but the patient has been suffering ever since her confinement. There is a constant sensation of tension toward the hypogastrium and of pressure toward the vulva. Walking is difficult; in order to facilitate it she places her hands on her abdomen. From time to time she experiences a sensation as though she had to go to the toilet. Lumbar pains have almost never left her; these sometimes radiate toward the groin, sometimes toward the thighs.

Menorrhagias. The duration of the menstrual period is longer than formerly. Flatulency; profuse leucorrhœa, especially at the approach of menstruation. Cephalalgia, palpitations of the heart, weakness, alarming emaciation. The patient wears, upon the advice of a midwife as well as two gynæcologists, an abdominal bandage. In the beginning she felt very well on wearing it, but lately the bandage has become so troublesome to her that she had to do without it. Vaginal tampons; cauterizations with silver nitrate stick; intra-uterine injections of iodine. Faradization of the uterus. This treatment produced greater relief than the others. Unfortunately, at the end of a few months she relapsed into her former condition.

I saw her for the first time in the end of June, 1877. The uterus is enlarged, retroflexed, very movable, somewhat soft, has not menstruated for the last 2 months. The cervix is large; a muco-purulent fluid escapes its external orifice; large ulceration. The ulceration affects the entire external orifice; it seems even to continue into the cervical canal. The patient wishes to be massaged. I refuse it, believing her to be pregnant, and I advise her to come back three months after her confinement. At this time she presents the same symptoms as before. Six weeks ago menstruation appeared, and just as painful as before. Length of uterus 9 cm.

Massage. The results obtained exceed my expectations, and this in spite of very extreme tenderness of the abdominal walls. The patient submits to the treatment with great perseverance. Dysmenorrhœa ceases; everything is gradually regulated and returns to a normal condition. The bearing down sensation as well as the pains in the back and the sensation of pressure in the perineal region and in the neighborhood of the anus have disappeared. Digestion is good; very little discharge. The patient looks strong and healthy. She has put on a good deal of flesh. The length of the uterus has decreased almost 1½ cm.; the consistency of the uterus is firmer. Complete cure was established after 6 weeks' treatment. I saw this patient again in February, 1878; cure has been maintained.

At the time when I stopped massage the ulceration had not entirely healed. Carbolic acid solutions applied to it for almost three weeks brought about a cure.

As the patient has not menstruated for the last 3 months she considers herself pregnant.

Prolapse of the Uterus and Vagina.—Brandt, Von Preuschen, Profanter have employed massage in these conditions. It was one of the measures of a method used, comprising: (1) Elevation of the uterus; (2) gymnastic exercises of the thigh muscles; (3) slight strokes upon the lumbo-sacral region.

The patient lies on her back, her thighs flexed upon the abdomen. The masseur stands at her left and faces her, with the palm of his right hand pressing the abdomen between the pubic symphysis and the fundus of the uterus, while an assistant, with one finger in the vagina, maintains the uterus in a position of anteversion. The masseur then seizes the uterus and its appendages with his fingers strongly curved. With this hand he draws the uterus up toward the epigastrium. When the uterus is drawn up as far as it can be drawn, the motion is stopped and the uterus slowly returns to its old position. The finger of the assistant follows this movement, and in consequence of the pressure which he exerts from before backward upon the vaginal portion he prevents the uterus from being retroverted. This elevation must be practised three times at each séance.

The gymnastic movements of muscles of the thigh consist of regular exercise of the adductors. The patient is in the same position, with the legs flexed upon the thighs and the thighs upon the abdomen. The masseur makes forcible passive movements, which are resisted by the patient. When the thighs are spread out the process is reversed; the patient tries to bring the thighs together, which the masseur opposes. Slight blows are made on the vertebral column and pelvis with the open hand.

I have not followed all the points of this operative manual. I have never been able to understand the utility of the first measure. Either the prolapse is the only symptom, or there is a malposition of the uterus, anteversion or retroversion. In the first hypothesis it is diffi-

cult to understand what good, efforts at replacing do. In a general way, when a malposition exists, it is due to continued action of the forces which cause it. Suppose that we admit that uncomplicated prolapse is of the same character as a hernia due to weakness of the abdominal wall—that is to say, its real cause is a stretching of the means which fix it. Will these shorten if pressure is made from below up? If, on the contrary, there is a retroversion maintained by pelvic adhesions, as is often the case, it is difficult to say that one single method of procedure can permanently overcome their resistance. M. von Preuschen considers the first measure as accessory; Brandt's measure succeeded through gymnastic exercise of the muscles.

The forcible adduction is accomplished by prolonged and forcible contraction of the levator ani, especially when the patient at the same time raises the hips. Owing to this, the lumen of the vagina diminishes; the uterus is forced upward with more or less force, and later on, when the treatment has been pursued long enough, it is maintained in this position.[1]

To this M. Sielski replies that the muscular contractions induced do not last long enough to constitute a means of fixation. Supposing that adduction produces powerful contraction of the levator ani, this muscle will easily tire out and the displacement recurs.[2]

[1]Die Heilung des Vorfalls der Gebärmutter durch Gymnastik der Beckenmuskulatur und methodische Uterushebung. Centralbl. f. Gynäkologie, No. 13, 1888, p. 201.

[2]Das Wesentliche in der Thure Brandtschen Behandlungsmethode des Uterusprolapsus; Modifikation der Methode. Centralbl. für Gynäkolog., 26 Jan. 1879, No. 4, p. 49.

This author forgets muscular tone. Mechanical measures are constantly employed to increase this tone. Whatever explanation may be given, the method has supporters. Brandt practised it during a visit to Jena at Professor B. S. Schultze's clinic. His results were good. Preuschen had equally good results at Greifswald; one was all the more remarkable as it had been used on an inveterate case. Profanter also recommends it.[1] None of the measures appear to me superfluous, but Brandt's method is uselessly complicated. Upon the uterus, steadied by the finger, pressure is exerted and massage is practised. The descended uterus rarely is absolutely normal, and usually presents evidences of a parenchymatous metritis. The patients complain of leucorrhœal discharges, metrorrhagia or similar symptoms. I need not mention that if the secondary displacement is slight these symptoms do not require much attention.

I must now make a few explanatory remarks. Is it easier to hold in place a healthy organ than one infiltrated, congested and increased in size and weight? The answer is not difficult. In the cases of prolapse which I have treated I employed massage in my accustomary manner, and employed movements of abduction. I have had good results and bad results. This is not against the method. I do not, however, believe that you can obtain the same results in these conditions as you get in cases of metritis. The treatment is directed to the uterus. Von Preuschen has noticed marked diminution

[1] Die Massage in der Gynäkologie, Wien, 1887.

in size. When the muscular tone is increased the flaccidity of the utero-sacral ligaments, which are relaxed and infiltrated, is lessened. All this is very well, but it would be too much to assume that the condition was permanently cured. The patients are able to walk and climb stairs; but if they are compelled to do hard work or make sudden movements or violent muscular efforts[1] the relief is only temporary and the prolapse recurs. This was the case with one of the two patients reported. Both came from the country, and seemed robust and rugged. One was the wife of a well-to-do farmer. I gave her minute directions as to how she should take care of herself after the treatment, especially cautioning her what she must not do. She followed my instructions and the relief was permanent. The second woman was a country-woman, well intentioned, but who could not change her work nor stop working. She left Paris in a satisfactory condition. A few weeks later not a vestige of the good effects of the treatment remained.

Having noticed how, in recent years, the operative treatment for prolapse has yielded most brilliant results, as the technique has improved, I have entirely given up treating cases of prolapse by massage. My countryman, Dr. Westermark, among others, has recently published the results he has obtained with his method. They are very satisfactory in regard not only to the immediate effects of the operation, but also to the permanent results; and in the majority of cases there

[1] And most of the patients suffering from this particularly disagreeable and painful affection belong to this class.

were no relapses in four or five years. Yet Dr. Prochownik, of Hamburg, one of the few who still adhere to this method of treating prolapse, in his work on pelvic massage[1] discusses this subject at great length, and reports many cases where he obtained good results without operation.

OBSERVATION XXX.

Prolapse of the Uterus and Inversion of the Vagina.—Massage.—Cure.

Mrs. L., 38 years of age. Two confinements, the first one two years after her marriage; labor very hard; got out of bed at the end of five days. She was imprudent enough to help lifting a wardrobe, when she noticed that she had produced a displacement of her womb. This accident was of no consequence, and she became pregnant again three months later. The pregnancy took its regular course. Confinement at term, healthy child. None of the confinements was followed by untoward symptoms, and the patient was able to get up at the end of the tenth day. This time she was foolish enough to lift her two children. She experienced a sharp pain in the lower part of the abdomen, and felt that something gave way. On lying down she felt much better. The midwife who was called in at this moment recognized a prolapsed uterus and applied a pessary. This was of little relief, because, in spite of the midwife's advices, she continued to tend to her household, and this gave her much pain. The pessary dropped out at the time of defecation, and it was impossible for her to replace it. A few months afterwards the prolapse became more marked than it had been at the beginning. It was accompanied by pains in the back and in the hypogastric region. On the slightest exertion the menstrual flow increases. There are menorrhagias, which weaken the patient a great deal. It is impossible for her to tend to her ordinary household duties. The midwife introduced a new pessary, larger than the first. After the patient had worn it for 4 months, without losing it a single time, she was obliged to remove it, because it brought on profuse vaginal flow, the latter of a bad odor.

I saw this patient the first time in the course of the summer of 1884. The prolapse could easily be demonstrated, and the uterus could be replaced into its normal position. The vagina was in a state of inversion, and appeared as though its mucous membrane had been exposed to the air for a long term. On the posterior lip of the cervix

[1]Massage in den Frauenkrankheiten, 1890.

there exists a large but superficial ulceration. By the hysterometer the length of the cavity of the uterus is 10 cm. No rectocele.

Massage is easy; but, owing to frequent interruptions, I am obliged to continue the treatment for the next three months.[1] At the end of the treatment the uterus occupies almost its normal position, still it presents a marked degree of retroflexion. Exertions or strains on the part of the patient do not disturb it. The length is 8 cm. The ulceration healed up without any special treatment. After separate massage of the vagina, this one has almost regained its former condition. Menstruation is regular and absolutely normal. No more leucorrhœa. I saw this patient in the latter part of April, 1888, i. e., about 4 months after treatment was stopped. The prolapse had not recurred. Her general condition is good. Following my advice, she abstained from working again in the country.

OBSERVATION XXXI.

Prolapse of Uterus.—Massage.—Cure.—Relapse, After Treatment Was Stopped, Under the Influence of the Same Mechanical Causes that Had Produced It.

Mrs. B., 48 years of age, country-woman. Her only pregnancy, 25 years ago, terminated at full term; habitual constipation. She noticed the prolapse of the uterus for the first time when defecation was very difficult. It occurred in summer, during harvest. Since then she experiences each time she applies herself to very hard work the same symptoms. Furthermore, she experiences just at that moment an extremely painful sensation, "as if the contents of her abdomen were going to drop out." Reduction is followed by marked improvement. She has pains in the back, frequent desires at micturition, constant digestive disturbances. Even when the prolapse is absent she suffers certain days more than others. Slight leucorrhœa. Vaginal injections of decoctions of walnut tree leaves, vaginal tampons without benefit.

Since her admission into Dr. Pacquelin's clinic I find that her general condition is excellent; the patient is robust. Menopause since three years. Uterus 9 cm., retroflexed. Vaginal inversion. All around the vaginal folds can easily be made out. The sound passes backward and a little to the left. Slight excoriation of the cervical orifice. Reduction is easily accomplished. When the patient remains quiet the tendency of prolapsing much less; reduction is more easy in the dorsal position. Deviaition of the urethra; micturition is impossible without preliminary reduction. Slight rectocele; perineum intact; the patient is unable to wear a pessary.

---

[1]By separate massage of the vagina the inversion almost disappeared after 5 weeks.

Massage. Painful during the first two weeks; pains in the lower part of the abdomen, radiating to the epigastric region. These persist a few minutes after the end of the séance.

After 9 weeks' treatment the uterus is almost in its normal position; still retroflexed. By the hysterometer the uterus measures 8 cm. The anterior vaginal wall is more resisting than it was formerly. The pains in the back, the digestive disturbances and the rest of the symptoms have almost completely disappeared.

I was informed by the patient's parents that she enjoyed good health for several weeks, but when she resumed her work in the fields the prolapse gradually returned, so that at the end of 2 months the benefit of her former treatment was all lost.

OBSERVATION (Von Preusschen) XXXII.

Prolapse of Uterus.—Massage.—Cure.

Mrs. L. de S. has had a total prolapse of the uterus for the last three years. It followed her confinement, and I have several times been called in to attend her. As the patient objects to any kind of operative interference, one must be contented to retain the uterus by a pessary. The only kind indicated is a hysterophore, held in place by a pelvic bandage, because any bandage getting its support from the vagina must necessarily be expelled by abdominal pressure.

The patient has since a short time left off her bandage, as it became defective. This was the condition when I presented her, the latter part of October, to my students. The tumor was about 11 cm. in length, and reached down to the thighs. The uterus can be felt in a position of retroversion; the vagina is in a state of complete inversion. The patient complains of pain on urination, and especially of very frequent desires at micturition. She also has a rectocele and cystocele.

I presented this patient, whom one could regard as cured, at a meeting of the Medical Society in Greifswald on February 11, 1888. Since the first few days that the patient came under my treatment the uterus remained in the pelvis, so that Mrs. L. is allowed to walk each day a short distance and climb a few steps; the uterus is now in anteversion, its length is reduced from 11 to 7 cm.; its transverse diameter has diminished in a like manner. As 3½ months have elapsed since treatment was begun, I consider her, without being too optimistic, completely cured.

OBSERVATION XXXIII.

Prolapse of the Vagina.—Cystocele.—Very Slight Sinking of the Uterus.—Massage.—Cure.

Mrs. A., 33 years of age, had only one pregnancy, which terminated 10 months ago at full term. Two months later she had an attack of intense pain at the vulva; slight pains in the back, hypogastric region

and groins. Walking was painful; she was completely tired out after her housework was done. Frequent and irresistible desires at micturition (patient urinates several times in the course of an hour). The greater the vulvar œdema, the more difficult the expulsion of the last few drops of urine. In order to evacuate the bladder she is obliged to press upon the tumor, which is projecting beyond the vulva, with her fingers. Vaginal injections of a concentrated solution of oak bark; not the slightest result. On examination in May, 1877, I find a tumor projecting from the vulva. It is soft, formed by the anterior vaginal wall, compressed by and containing the bladder.

Reduction is easy. When the patient carries her child on her arms for some time, and especially when pressing down, the tumor assumes the size of a small fist. The uterus is large, slightly lowered. The patient is in the upright position; I massage the tumor with the tip of the right index and middle fingers by pressing it repeatedly against the pubic arch. At the end of a month the vaginal wall is replaced, reduction of the tumor is accomplished without any noticeable difficulty, but there still exists a tendency to cystocele; nevertheless I continued the treatment as heretofore and with a great deal of force. This causes pretty sharp pains in the back and in the inguinal regions. At the end of a week these pains have greatly diminished, and the patient can bear them very well. The contents of the bladder are always evacuated before each séance.

Improvement was soon perceptible. When the tumor did descend it presented a smaller surface than formerly and was less flabby. After 48 séances, interrupted only at the menstrual periods, the tumor was of the size of a hazel nut; it was firmer in consistency, and it did not increase in size afterward; no more frequent desires at micturition. She urinates only twice a day. I advised her to avoid fatigue, and, above all, not to lift or carry heavy weights. I saw this patient again on June 22, 1878. Since the last examination the tumor has diminished still more in size.

FIBROIDS.

I have often employed massage in the treatment of small and medium sized fibroids, and obtained some improvement. It is a palliative measure often applicable and harmless. There are many peculiarities in the development of fibroids. Among others are symptoms resulting from their irritation of the uterine wall, metritis of that portion of the uterine tissues in proximity to them, which gives rise to menorrhagia, metrorrhagia

and leucorrhœa. It is to these secondary changes that treatment must be directed.

Massage here acts in the same manner as electricity, to which, as is well known, Apostoli has given his name. Massage chiefly affects the metritis, i. e., the endometritis, whose chief symptom is the hemorrhage, and not the tumor itself. For example, in case XXXIV a girl 18 years of age had become so anemic on account of the incessant metrorrhagia that her restoration to health seemed doubtful. She had several fibroids. Under the application of massage her metrorrhagia stopped, her health returned and, in spite of my remonstrances, she married the next year. No untoward symptoms followed her indiscretion. The diminution in size of the tumor sometimes noticed after massage, just as after electricity, is due to the disappearance of the oedema surrounding the fibroid, and gives you the impression as though the fibroid itself had diminished in size.

It has seemed to me that in the interstitial variety the procedure is equally applicable. It causes the tumors to become more superficial, at the same time, however, the surface of the uterus often becomes uneven. It is advantageous for them to become superficial. Subperitoneal fibroids grow more rapidly, but are better tolerated. Submucous fibroids become more accessible and capable of complete removal. Freudenberg, Ziegenspeck and Brandt report cases where small fibromata had disappeared. I have not had the same experience. I also apply massage in large myomata, if the pain does not contraindicate it. Their growth, especially if rapid,

causes tension and irritation of the serosa, which invests it, from which various kinds of abdominal pains arise. These pains are not all due to the friction of the serous surface, but as Ziegenspeck has shown, to the adhesions of the tumor to the surrounding pelvic organs. According to him, the growth of the tumor is not arrested at the menopause, although the uterus at this time becomes more anemic. The nutrition of the tumor is increased by the increased quantity of blood going to the growth through the adhesions.

In all cases where there is more or less constant pain in the region of the tumor, with tenderness on pressure, it is necessary to apply massage very gently. When massage is applied in this way for several weeks not only the slight adhesions due to the perimetritis will disappear, but the thicker adhesions will also become attenuated to a marked degree.

OBSERVATION XXXIV.

Multiple Uterine Fibromata.—Dysmenorrhœa and Metrorrhagia.—Extreme Weakness.—Massage.—Cessation of the Metrorrhagia and the Dysmenorrhœa.—General State of Health Improving Wonderfully.

Miss L., 18 years of age, comes to consult me in the month of March, 1878. Menstruated the first time at 14 years of age. Duration of the periods 5—6 days; nothing abnormal about them. She then went six months without any sign, when the periods returned suddenly. The duration of the subsequent menstrual periods became longer, and they were at the same time accompanied by acute pains in the back and in the loins, sometimes on the left, sometimes on the right side. Violent at the approach of the menses, they gradually diminished as the menstruation progressed. Since 1873 the duration of the menses has increased, so that finally the flow has become almost constant. Since last spring the menses are incessant, so that it is almost impossible to make out the precise moment of the menstrual period; frequent desire to urinate; obstinate constipation; œdema of the feet and the malleolar region.

Astringent vaginal injections and disinfectants, when the discharge assumes a bad odor. Iron, quinquina, ergotine, all these without any ameliorations. For the last four months the patient has been obliged to remain in bed for the greater part of the time. The blood has daily grown paler, without any tendency to coagulate. She has become thin and weakened to such an extent that she cannot walk; she is particularly unable to get upstairs without assistance. Constant cephalalgia; palpitation; the least effort provokes giddiness; anorexia, aversion for all food. Sleep irregular, often insomnia; discouraged, ideas of suicide; extreme emaciations; dirty, grayish color of the face.

Uterus slightly displaced backwards. Gives to the touch the sensation of an irregular mass, because it is the seat of several fibromata, most of them the size of a walnut. They are more or less prominent on the external uterine surface. The hysterometer is introduced with quite some difficulty (8.5 cm.).

Two weeks after the beginning of massage the young girl declares that she is already losing less blood. After 6 weeks, marked ameliorations. Metrorrhagias are less abundant; the other symptoms have also diminished. She is able to walk and come alone to the office, whereas formerly she could not do so without leaning on the shoulder of her mother. The appetite has come back. It is rather ferocious. No more dysuria or trouble on micturition. Sleep, quiet. Under the influence of the same treatment, prolonged for several weeks, the metrorrhagias ceased completely. The fibroid tumors have not decreased in size. They seem to be even more prominent than before.

I saw this girl 4 months later at her home. On my arrival I saw her jumping a rope with other girls of the house. She has grown stout Can walk and make extensive tours on foot. Menstruation is re-estab lished, but the duration is always long, lasting 9 days. Micturition and bowels normal. Her parents asked me how I was disposed toward her idea of entering matrimony. I gave an unfavorable advice, telling them of the possibility of a return of the affection. My advice, however, was disregarded, and she married toward the end of the same year. I have seen her several times since. Her general state of health has remained excellent. Fortunately she has not become pregnant. Menstruation is regular, of the monthly type, and lasts 9 days, painless, not excessive. Patient always looks pale, but does not complain of anything.

OBSERVATION XXXV.

Pediculated Fibromata of the Uterus.—Repeated Metrorrhagias.—Extirpation.—Massage in Order to Facilitate Involution of the Uterus.—Presence of a Second Tumor.

Mrs. N., 33 years of age, the wife of a grocer, had three normal confinements, the last one two years ago. Enjoyed good health up to that time. I saw her for the first time in December, 1878. Since 8 months the menstrual periods increased in time; there was

almost never more than 8 days' interval between two menstrual periods. The menstrual flow was always moderate. Her general health had as yet suffered little; her appetite was excellent; she was able to walk and tend to her ordinary occupation. Painful sensation, not well defined, in the hypogastric region. Constant pains in the back; these have lately assumed a sharper character. No other symptoms but a certain weakness oblige her now and then to lie down during the day. Her complexion is pale, yellowish.

On local examination the uterus is found very much enlarged, without any appreciable prominences; its consistency is rather diminished. The margins of the external orifice are very thin; the cervix is sufficiently open to admit the tip of one's finger. Immediately above the external orifice there is a tumor, of rather firm consistency, which completely fills the cervical canal and dilates it. It is impossible to make out its boundaries with the finger and to get to its point of implantation. One of my colleagues and I dilated the cervix sufficiently with a tent as to gain the point of implantation of the tumor. It is situated to the right of and a little above the cervix. The tumor is attached to the wall by a rather small pedicle; still, it is of the size of a hen's egg. My colleague utilized the dilatation obtained and extirpated the tumor. Subsequent intra-uterine exploration demonstrated that there existed several other small tumors, in all probability of the same kind. One of these is located on the posterior wall. It presents a round surface, slightly projecting, of the size of a walnut. Extirpation of the first was followed by momentary arrest of the hæmorrhages.

In order to facilitate subinvolution of the enlarged uterus and to hasten, as we entertained such hopes, the expulsion of the second tumor, or at least to produce a displacement so as to render it accessible, as in the first instance, I tried massage for some time. The patient rested a good deal; I then began the treatment and continued it for 6 weeks. For 5 weeks after the treatment I did not hear from the patient. Then I was told by her that she had suffered for the past 3 weeks from symptoms similar to those she experienced before the operation. On local exploration I found the second tumor to have assumed a position similar to the position occupied by the first tumor. It was easily reached. The patient refused, however, an operation to have it removed. Since then I have not heard from her.

OBSERVATION XXXVI.

Multiple Fibromata of the Uterus.—Rebellious Metrorrhagias.—Massage.—Improvement.

Mrs. G., 34 years of age, consulted me in October, 1878. Had three normal confinements. In the course of a fourth pregnancy she suffered a fall in the street, which was followed by a miscarriage; she had to remain in bed for 4 weeks. Five years ago, in the interval between the second and third pregnancies, she experienced a sensation of heaviness and pain in the lower part of the abdomen,

aggravated on standing. Dysuria. Rebellious constipation. After having lasted for 5 days the menstrual flow becomes more abundant and is at times prolonged for a week, gradually assuming the character of true metrorrhagia. It has become impossible for the patient to know the time corresponding to her menstrual period. Lately the discharge has become serous, tinged with blood; no more clots.

On bimanual examination the uterus is found very much enlarged and lying towards the front. Upon its anterior surface I find several hard and resisting tumors, whose size varies from that of a cherry to that of a hen's egg. The greater part of the tumors seems to be of the interstitial variety. In the posterior cul-de-sac I find one of the same consistency as the preceding ones. On rectal examination it is possible to follow it up to the fundus of the uterus. By the hysterometer the uterus is found to measure 9.5 cm. It is irregular. The irregularity is due to the prominence of the wall at the seat of the tumor. This seems to join the tumor felt in the cul-de-sac.

Massage. Metrorrhagia diminishes; the blood gradually assumes its normal color and consistency. Treatment is only interrupted during the supposed menstruation. At the end of 3 months, no more loss of blood, desires at micturition less frequent; obstipation only slightly improved. In order to build up her general condition, a sojourn in the country is advised, as well as internal administration of tonics.

Local examination shows that the size of the uterus has diminished 1 cm. in length. The tumors are in exactly the same position as they were before the treatment. I saw this patient again in the latter part of August, 1879; improvement continued; the duration of the menstrual periods 5 days; the quantity of blood normal. The last menstruation was, however, more abundant, so that the patient became somewhat alarmed and consulted me again. Otherwise the patient is in about the same condition as she was at the time when we stopped treatment. On vaginal examination, the finger introduced into the external cervical orifice easily reaches the internal os; this seems to be dilated and to have enlarged since treatment was stopped. One of my colleagues and myself introduce a tent to dilate the cervix, and we recognize that the tumor causes a prominence, much more pronounced in the uterine cavity than we were able to demonstrate at the last examination with the sound. I saw this patient again one year later, and she informed me that the tumor had been removed.

OBSERVATION XXXVII.

Large Uterine Fibroma.—Retroversion of Uterus.—Profuse Metrorrhagias.—General Weakness.—Massage.—Diminution of Metrorrhagias.

Mrs. M., 34 years of age. Twice pregnant; the last time 3 years ago. At first menstruation lasted longer than usually, and the amount of blood lost gradually increased; finally, the intervals between the periods diminished and became very short. The frequent metrorrhagias soon brought about marked anæmia, obliging the patient

to remain in bed from 6 to 7 days, corresponding to the menstrual periods. The patient very soon complained of a sharp pain in the back, lancinating pains in the groins, especially on the left side, accompanied by a sensation of heaviness in the lower part of the abdomen. Micturition frequent, but without pain. Hypogastric counter-irritations with tincture of iodine, vaginal injections of perchloride of iron; fluid extract of ergot, internally; suppositories of opium and belladonna in the rectum; internally, iron and wine of quinine.

I saw this patient for the first time in April, 1878. She is very anæmic, complains of constant headaches, buzzing in the ears and marked tendency to syncope, even on the slightest exertion. Countenance pale and cadaverous looking; œdema underneath the eyes. On palpating through the thin and flabby abdominal walls I can make out a resisting tumor of the size of a woman's or child's fist. This tumor occupies a large part of the anterior wall of the uterus. The hysterometer moves freely in the uterine cavity without encountering any prominence. Length of uterus, 9 cm.; consistency, firm; slight retroversion. The patient complains of obstinate constipation, which resists all remedies.

Massage produces at first but slight improvement. I must remark here that treatment was followed very irregularly. At the end of 2 months, however, it became evident that the periods came on less frequently and less profusely. At the end of 3½ months I thought to be in a position to stop treatment. Since a fortnight the patient has not suffered the slightest loss of blood. Her appearance has changed; her strength has returned; the uterus is slightly diminished in size, length 8 cm. The fibrous body has apparently assumed more prominence, arising from the side of the peritoneal cavity. Constipation is improved; urination is not so frequent.

I saw this patient again in April, 1879. No more metrorrhagia; menstruation from time to time somewhat profuse. She has gained flesh, and the cachectic look she had formerly has almost disappeared.

OBSERVATION XXXVIII.

Uterine Fibromata.—Repeated and Profuse Metrorrhagias.—Massage.—Disappearance of the Metrorrhagias.

Mrs. L., 32 years of age. Since 1875 her menstruation is more profuse and of longer duration than formerly. After her last confinement (March, 1873) she felt a violent and very painful pressure in the hypogastric region, accompanied by difficulty in micturition. This painful micturition was accompanied by rectal tenesmus. I saw this patient for the first time in January, 1878. At that time she presented a striking secondary anæmia of some duration and accompanied by great pain.

Here is the history furnished by direct examination of the internal genital organs: The uterus, slightly displaced forward, is more resisting and firmer than normally. On the fundus and the anterior uterine

wall three fibrous tumors, of different sizes, can be felt; none of them exceeds the size of a pigeon's egg. The lower segment presents nothing abnormal. With the tip of the finger I can pass the external orifice for a short distance into the cervical canal. By the hysterometer we measure 9 cm.; it passes into a pretty large and roomy cavity. At the above level it strikes a small tumor projecting into the uterine cavity.

Ice cold vaginal injections; ergot; injections of laudanum solutions to quiet vesical irritation and to relieve the pain on urination.

Massage. After a few weeks, manifest improvement. Metrorrhagias have greatly diminished, and the patient is able to take long walks without fatigue. The first menstruation following the treatment did not resemble the ones that preceded. The amount of blood lost is less; less symptoms point to the uterus and bladder. The patient was doing well after 10 weeks' treatment. Menstruation is regular and normal, and not accompanied by any pain in the lower part of the abdomen. Her general condition is good, and she no longer presents such a cadaverous appearance. The uterus is slightly diminished in consistency and size. The fibrous tumors are not changed; they seem to be even more prominent than before the treatment was started. She is advised to go to the country, and to take iron internally. I saw this patient again in December. Since she has stopped treatment she has not suffered, up to June, from menorrhagia as to attract her attention. She has been able to continue at her work as laundress without experiencing any symptoms that obliged her to interrupt her work.

PART II.

MASSAGE OF AFFECTIONS OF THE NEIGHBORING STRUCTURES OF THE UTERUS AND ITS ADNEXA.

CHAPTER IX.

Operative Manual.

The precautions to be observed in massaging affections of the adnexa are the same as for the uterus.

The patient is told to breathe easily, without any effort, and her attention is distracted as much as possible, so as to relax the abdominal muscles.[1]

In order to perform massage as it is usually practised, that is, through the vagina and abdomen, the procedure is as follows: Two fingers introduced into the vagina press the perineum downward, and at the same time the patient is asked to elevate her pelvis. The elbow of the physician is depressed as much as possible. This procedure enables the fingers to reach higher and thoroughly explore and treat the pelvic contents, which sometimes, owing to either a fat or a rigid perineum, are

[1]Some patients have great difficulty in relaxing the muscles of the abdominal wall; others easily, and some never learn to relax them.

difficult to reach. The tips of the two fingers are passed into one of the cul-de-sacs of the vagina and press the exudate toward the hand on the abdomen as much as possible.

Thanks to this manipulation, the exudate can readily be reached and massaged without causing the patient much pain. In places where the organ is fixed, the same must be got to through the vagina and abdomen. When the exudate is situated near the posterior wall of the pelvis the fingers in the vagina must be passed up a greater distance, more pressure must be employed and the tactile sensibility of the fingers is blunted. In these cases the rectal route is preferable.

When practising the vaginal touch with the index and middle fingers the ring and little fingers usually are flexed on the palm of the hand. The pressure of the bony surfaces of the first and second phalanges is painful for the patients. I prefer to hold these fingers extended, as Brandt has advised, compressing the perineum. In this way the fingers can be pushed higher up and cause less pain. In certain rare cases it is better to have the patients stand upright during the examination, as well as while massaging. Exudates high up in the pelvis are better reached in this way than if the patient were lying on the back. The part played by the vaginal fingers is mostly a *passive* one, when performing massage properly so called, and then they only support the organs or inflammatory products which are being massaged by the other hand through the abdominal wall; that is to say, these fingers, as when massaging the

uterus, must remain perfectly steady and must only be moved when another portion of the exudate is to be massaged. Brandt properly advises that circular frictions on the abdomen be made immediately before each séance. The skin becomes accustomed to contact of the hand and its sensitiveness is diminished, as well as that of the adjacent muscles. You can thus depress the abdominal wall more easily and push back the intestines, so as to allow you to more easily reach and grasp the parts to be massaged. In the majority of cases it is well to have the patient assume the same position as in massage of the uterus. Too much arching of the vertebral column must be avoided, especially of the lumbar region, for this would push the abdominal viscera forward and increase the rigidity of the abdominal wall.

To repeat what I have mentioned in massage of the uterus, in order to get a good hold of the exudate, it is necessary to press gently and slowly on the abdominal wall and avoid any jerky movements, which would only cause pain and increase the sensitiveness.

In compressing the abdominal wall advantage is taken of expiration, in order to press back as far as possible. Care must be taken not to lose what has been gained during inspiration. At each expiration you press a little further.

Vulliet rightly advises that the palmar surfaces of the last phalanges be used rather than their tips, because less pain is caused. When the exudate has been reached, sufficient time is given to the patient to permit her to recover from this disagreeable sensation, pro-

voked by the physician's grasping the structures which he wishes to massage.

Are the abdominal walls ever too thick, rigid or sensitive to permit reaching the exudate without great difficulty? In such cases follow the instructions given by me in massaging the uterus. Thanks to these gentle frictions, the skin becomes less sensitive, the muscles less irritable, intestinal distention less, which to a great extent interfere with massage.

Massage must always be performed in the direction of the venous and lymphatic circulation; that is to say, from the neighborhood of the uterus toward the pelvic wall, sacroiliac and sacral regions. Here, likewise, we must observe what we have repeatedly called attention to under massage of the uterus and abdomen. Previous to the first séance the patients complain of but one kind of pain, that which has troubled them for a long time. After the séance this has not diminished and there has been added another pain. The aphorism that two pains neutralize each other does not apply here. The patients very clearly state that they are suffering as much after as before massage, and, moreover, they are complaining of pain in certain parts of the abdomen which they cannot very well localize. This is due to the traumatism. It is, however, of trifling importance, and lasts but a few days.

I have stated that you must proceed gently and methodically, otherwise you will encounter difficulty which will almost always prevent your carrying out the

treatment. Gentle pressure and short séances are the invariable rule at the beginning.

It is also necessary that you be careful not to make any sudden and rough movements. The tissues must be held firmly, for their slipping between the fingers will cause stretching of the nerves and produce considerable pain. When you have sufficient confidence, and the patient is accustomed to the manipulations, you may increase the length of the séances as well as the pressure. The séances may then last five to ten minutes. It is well to rest a short while several times during the séance. The doctor himself, too, will find this advantageous, for it enables him to recover his strength. By pausing I understand momentary stopping of all active manipulations; whatever has been seized, must not be allowed to escape one's grasp.

Another equally useful precaution to lessen fatigue is to massage with the hand opposite the exudate. If the exudate is on the left side, for instance, the right hand is employed to massage the abdominal wall, the left index and middle fingers being inserted in the vagina for support. I employ the two manipulations recommended by Brandt—pétrissage and tension.

1. *Petrissage* is the more useful and more frequently employed. You rub, or, rather, knead, as the word indicates, the affected portion, with the fingers of the right hand gently and slowly pressed into the abdominal wall. The two fingers in one of the vaginal cul-de-sacs serve as a guide, and support as well as control the abdominal hand. Pétrissage is, moreover, serviceable when there

exists a chronic infiltration anywhere in the pelvic cellular tissue or old inflammatory remains in the broad ligaments. The amount of force used must be determined by the sensitiveness and consistency. You must always begin at the periphery and work toward the centre.

2. *Stretching* is a useful manipulation which is scarcely employed, except in Gynecology. Prochownik uses the term *Zugdruck*,[1] a very appropriate term, as it combines stretching with pressure. This term always comprises these two manipulations, to both of which frictions are frequently added with advantage. The object is to grasp the structures to be treated and stretched between the tips of the fingers inserted in the vagina and those acting through the abdominal wall. If these are small it is difficult to grasp them, the intra-vaginal or intra-rectal fingers exercising a slow, gentle, steady tension on the exudate, which is pushed toward the right hand. After a while the vaginal fingers are slowly withdrawn, and the abdominal hand follows them down.

Prochownik permits the fingers which support the exudate, through the vagina or rectum, to take only a passive part in the majority of cases. I have sometimes endeavored to practise the procedure with both hands acting at the same time, only the tips of the internal index moving. At every séance the manipulation is repeated eight or ten times. Later on it may be repeated ten to twenty times without causing any discomfort.

---

[1]Massage in den Frauenkrankheiten, s. 890.

Of all the manipulations, stretching requires the greatest care, skill, tactile sense, great steadiness of the hand and accurate judgment of the amount of force required. The slightest disregard of these precautions may cause disagreeable symptoms. The object should be to make the exudate more supple and distensible, without necessarily causing their complete disappearance. Above all, their rupture must be avoided. Whenever the adhesions are firm and strong, stretching is indicated; likewise, when chronic retracted inflammatory products (true cicatrices) are present in the broad ligaments. Here this may be used alone or with pétrissage.

Displacements of the pelvic organs are the natural and common results of exudates. The uterus is frequently employed as a lever in stretching. This is hardly possible with other organs, as the tubes and intestines.

Sometimes the examinations are so painful to the patients that exact information of the condition of the uterus and its adnexa cannot be obtained. This is to be deplored. Next to an exploratory laparotomy, massage gives the most precise and complete diagnosis. In some cases, however, general anesthesia must be resorted to. Most physicians, however, regard it as a last resort. It is well to repeat here that chloroform anesthesia is without danger, and is employed here to relieve slight pain; nevertheless patients will object to a method of treatment which is thus begun. Even if the patient fears the pain more than the rest and is willing to readily submit to any measure capable of sparing her

pain, her opposition is not ended. Other circumstances must be considered. The dangers of anesthesia are known to them. In spite of what the physician may say, very few want to submit to anesthesia simply for the sake of diagnosis. Besides, they think that it may be necessary to be chloroformed a number of times, perhaps at every séance. If in addition all obstacles have been overcome, and it could be said that we now have the means of making as methodical an examination as possible, we might be mistaken. Even though objective symptoms have been clearly demonstrated as being present, however important and serious they may be, this is not always sufficient.. The local modifications of the sensitiveness present a semeiotic interest of first order; often they alone give informations concerning the age of the exsndate as well as the disposition of the acute phenomena.

All authors have not wholly adopted the operative manual which I have described. It is necessary to modify this in some cases. Brandt introduces but one finger into the vagina. I see no advantage in this. You cannot reach as high as with two, unless you have, as he had, an exceptionally long index finger. Ziegenspeck has rightly remarked that the sensations appreciated by one finger are less precise than those obtained by two fingers. Strictly speaking, you cannot make out the inequalities, thickness and extent of the parts to be massaged as well. With two fingers, however, you obtain, as it were, a *stereoscopic* view.

In discussing massage of the uterus I have stated

that there is no advantage in massaging through the rectum. Here, however, I must be less positive, or, rather, hold the opposite view. In many conditions the rectal route is preferable. In others it is the only one that can be chosen. In virgins it is impossible to employ pelvic massage except through the rectum. Moreover, with a little experience one acquires very accurate information as to the condition of the pelvic organs. The rectal method is, furthermore, the route of election whenever the exudate is situated in Douglas' cul-de-sac, whenever the exudate is situated very high on one side of the iliac fossa and when massaging ovaries adherent to the posterior pelvic wall or prolapsed and fixed in Douglas' cul-de-sac by adhesions. This route is not a more difficult one than the vaginal. The tip of the index finger is introduced as in ordinary examinations, then it is directed towards the anterior rectal wall, in order to explore, support, and sometimes be employed for massage also; that is to say, you employ the rectal finger as a sort of support, in such a way as to approach the fingers which are massaging the exudate through the abdominal wall, and vice versa. The rectal finger takes the corresponding action of the vaginal in pétrissage or stretching.

A special manipulation to which Brandt has attached great importance can only be applied through the rectum. He calls it *malning*, a term for which there is no English equivalent. It is as follows: The patient lies in the dorsal position, the legs flexed on the thighs and the thighs flexed on the pelvis. In some cases the

vertical position is indispensable. The doctor introduces the index finger into the rectum and makes gentle and steady frictions with the last phalanx on the exudate. Malning is really only a kind of mediate effleurage, since there intervenes the rectal wall and more or less thick layer of cellular tissue between the massaging finger and the exudate to be absorbed. When the tenderness has diminished, which usually occurs after a few séances, more force may be used. Malning then becomes a species of friction.

The patients sometimes experience in this last manipulation very sharp pain in the buttocks and thighs, which indicates either that you are very close to the sacral plexus or that you have touched some of its branches. If care is exercised it is easy to spare patients these pains. This region should be avoided. The latter mode of massage is very useful for exudates lying in Douglas' pouch. In consequence, these exudates are frequently absorbed and the attachments to the uterus freed.

Just as in chronic metritis, the menstrual epoch exerts a favorable influence to promote absorption. We are often fortunate to find, on resuming the treatment after menstruation, that the local condition has spontaneously improved. Brandt and Niessen, of Christiania, thought that one might take advantage of this physiological process, in order to hasten the cure. Accordingly, it would be well to continue these manipulations during menstruation. There would be no more danger at this time than at any other. By slightly shortening the séances and great gentleness one might

continue the treatment and avail himself of the combined advantages of massage and menstruation. Brandt followed this procedure in a great many cases without ever having cause for regret. I am less convinced of the advantages of this procedure. Menstruation is a period of active local nutrition, even heightened. You must not rely too much on the phenomena accompanying it. Holzappel does not countenance pelvic massage during menstruation, since he is afraid of causing retro-uterine hematocele, among other dangers.[1] I do not think this fear is well grounded, for I have never heard of such an untoward symptom occurring. It might occur if proper care is not used.[2]

Some objections of a different kind have been made by the patients themselves. They are perfectly willing to submit to these manipulations, which are more painful during menstruation than at any other time, provided they are convinced that the continuation of the treatment will be more efficacious and shorten its duration. I have had considerable experience, but cannot entirely share this conviction. Following Brandt's advice, I have tried massage without interruption in a few very favorable cases, and I noticed that the absorption was more rapid in only some of them. Neither am I an adherent of the combined method of massage and Swedish gymnastic movements. Brandt did not want to

---

[1]Aus d. gynäkol. Klinik d. Professor W. A. Freund, Strassbourg, October, 1890.

[2]Note.—I have only in exceptional and quite stubborn cases been obliged to resort to this procedure.

employ one without the other. These were two inseparable elements of one and the same method. Many of his pupils have strictly followed this rule. To them, without Swedish movements no cure was possible. It was impossible to say which was the essential and which the adjuvant.

Pelvic massage is the therapeutic procedure directly applicable in affections of the neighboring organs of the uterus and its adnexa. Gymnastics have different indications. This is my way of looking at it, for one of the best arguments we have advanced in favor of massage is that it is a local measure applicable even to the seat of the lesion. We have to deal with a morbid process, which has no tendency to regression—with an inflammatory exudate and its results, which occasion local and distant disturbances. It is necessary that these must disappear. I believe that an indirect manipulation, no matter how judiciously applied, does not act in a sufficiently accurate manner to be efficacious. It is difficult for me to understand how movements of the legs, thighs and vetebral column could influence a wide area of inflammatory infiltration in the pouch of Douglas, the broad ligaments or a periovaritis. We must, however, appeal to the facts. Unfortunately, to prove this experimentally, one can oppose it with others equally as experimental. Those affections which Brandt and his pupils cured by massage and Swedish movements we have cured just as thoroughly and rapidly with massage alone and no gymnastics. Moreover, the most evident result of this combination of two methods is that it pro-

longs the séance and uselessly tires out the patient at the same time that it unnecessarily increases the amount of work to be done by the physician.

I do not, however, wish to be understood as condemning gymnastics. They may be useful at the proper time. When the patients have completed the course of treatment by massage, gymnastic exercises are sometimes indicated. In a large number of cases the general symptoms become at times almost as alarming as the local ones. As a result of the prolonged suffering and the repeated hemorrhages and leucorrhœa, the patients become often anemic and nervous and lapse into a condition of languor, which prevents their performing their ordinary duties. When the pelvic exudate has disappeared, when the subjective symptoms have markedly improved, as is expected, adjuvant methods may successfully be resorted to. Among these, gymnastic Swedish movements are one of the best.

Let us now describe what takes place when massage is begun. Before the first séance there is almost always slight psychical excitement. The patients come often to the doctor's office discouraged and in despair, and alarmingly inquire what the physician is going to do for them. They ask if so simple a procedure will cure them when so many methods of treatment, more complicated than this one, have failed. There is frequently slight hyperesthesia at the beginning of the

séance and some nervousness at the close.[1] At the second séance matters are quite different. You no longer encounter the instinctive rigidity at the slightest pain on touch. Several séances, however, are in most cases necessary before the patients sufficiently relax their abdominal muscles. Different patients vary greatly in this respect. Some patients are more tractable than others. If massage is properly performed there ought to be no pain after the séance.

It is well to warn patients that the tenderness of the massaged parts, like that of the abdominal walls, is increased during the first few séances, on account of the pressure employed. This increased sensitiveness disappears quickly, as in massage of the uterus, and at the end of a few days is entirely gone.

In more difficult cases the doctor had better stand, with his body slightly bent. In this position he can exert the greatest amount of force with the least fatigue. This is an important point when a great deal of force must be used—force without the slightest violence, especially when the exudate is of long duration and very hard or seated high up in the pelvis, and consequently difficult to reach.

Besides the local pain, the manipulations sometimes, although rarely, cause more or less pain in the neighboring or distant organs. They may be as severe as those

[1]This remark hardly applies to Scandinavian countries, but only to those where gynecological massage is of recent adoption or not known at all. In Sweden, where its nature is well known, the method is easily applied, and patients submit to this as readily as to any other treatment, without fear or hesitation.

of which the patient is complaining. I have seen vesical pain and tenesmus, and a feeling as if something were pressing on the rectum. Some patients complain of pain in the left ovary when the right is massaged, and vice versa. Others experience cutting pains in the epigastric region; these are very variable, appearing in some séances and not in others, and often may be very painful. Generally these disagreeable pains, due to radiation or of a reflex nature, disappear after a few séances.

I usually have only one séance a day. It might be desirable to have two or even three, when dealing with a large, hard, chronic and insensible exudate.

The treatment requires from two weeks to three or more months. Ordinarily from three to eight weeks are required.

The results, in parametritis, are at least as good, if not better than in metritis.

Those exudates which are large and at the same time hard are very obstinate. One might perhaps be able to cause their complete disappearance in a few cases by massaging with one or two hands through the abdominal wall only. When the exudate has sufficiently diminished it is always necessary to employ the fingers in the vagina or rectum, as has been described above, in order to support and control the movements of the external hand.

The symptoms frequently disappear in the same order that they have developed. The pain in the loins is frequently the most obstinate of all. Nervousness and reflex symptoms are equally rebellious. Constipation is generally relieved. This is the experience of all who have

employed pelvic massage considerably. I have seen patients who for years were unable to move their bowels unless they took injections or laxatives, have daily spontaneous, painless evacuations after having been massaged three or four weeks. This apples especially when the exudate is in Douglas's cul-de-sac. The improvement in this particular is not in proportion to the diminution of the exudate. The general improvement is also marked. Many of the patients are so weak that they are hardly able to go about. They are agreeably surprised at the end of three or four weeks that they can attend to some extent to their ordinary occupations and often take rather long walks. It must be remembered that many of these women have submitted to other methods of treatment, and that the majority of them tried massage as a last resort, to satisfy their consciences. They have only a vague hope of obtaining a radical and complete cure by this means. It cures, and this is the reason for its employment. The more it is used the more it gains ground.

Unless it succeeds, obstacles will not give way to it.

We shall now discuss the principal affections of the vicinity of the uterus in which we have employed massage, and give the histories of cases.

CHAPTER X.

Parametritis.

Difference Between Para- and Perimetritis.—Varieties According to the Seat.—Varieties of Exudates.—Manipulations Required.—Cases.

The term parametritis is applied to inflammation of the pelvic connective tissue, whereas the term perimetritis is applied to inflammation of the pelvic peritoneum. Both are frequently due to the same cause, but their pathology and complications differ. They do not yield to treatment in the same way. Perimetritis is productive, and forms new tissue, and almost always causes adhesions which bcome organized and are with difficulty caused to disappear. Parametritis is often due to a simple infiltration of the pelvic connective tissue—a true œdema; fibrous transformation corresponds to a more advanced stage. The distinction between chronic para- and peri-metritis, while indispensable from a clinical and therapeutic point of view, is artificial, and represents only a stage of the same process. To repeat here what I have said under chronic metritis, it is impossible to imagine an inflammation of the pelvic peritoneum, however circumscribed and sub-acute without its invasion of the adjacent connective tissue. It cannot be conceived but that in the course of a cellulitis the serous covering would be involved.

There is a difference in the formation as well as in the structure. When the cellular tissue is more involved it is called parametritis.

This affection is most frequently due to labor and miscarriages. It is also observed after operations and prolonged examinations without proper antiseptic precautions. Its onset may be latent or insidious. The acute stage then is absent; the exudation is produced without any warning. The patient only knows of its presence by the dysmenorrhœa, persistent leucorrhœa, pains in the loins and frequently by the other symptoms peculiar to chronic pelvic affections.

Gonorrhœal parametritis, independently of salpingitis and perimetritis, occurs but infrequently. The gonococci pass from the interior of the uterus to the tubes. The infection is thus carried directly to the peritoneum and not through the cervical lymphatics. The condition may occur alone, or with ovaritis, periovaritis, salpingitis, and, above all, chronic endometritis, i. e., metritis, which is frequently the same thing, being frequently due to the latter.

As I will show later on, there is established, under certain circumstances, a vicious circle, the parametritis causing the endometritis. In these cases it might at first be difficult to determine which of the two was first present. Contrary to the general rule in medicine, it is the result here which first must be treated, and only when this has disappeared must you attack the endometritis.

The extent, location, size and consistency of the exudates vary a great deal. I have seen some which com-

pletely filled the pelvis. The rectum, completely surrounded by hard masses, had scarcely sufficient lumen to permit the passage of fæces. In many, the exudate is very thick and of considerable extent. Such cases are not always the most favorable for treatment. The shape is equally variable, and sometimes difficult to make out. At the outset the exudate proper is surrounded by a zone of œdematous bogginess, which causes the outlines of the exudate to become indistinct. Frequently the lesions exist near the uterus or especially at its sides. Sometimes they are situated so high up in the pelvis that it is almost impossible to reach them through the vagina.

Exudates of Douglas's cul-de-sac are common. I have met with post-cervical cellulitis, which is, I believe, more frequent than is ordinarily described. As it frequently exists with exudations in Douglas's cul-de-sac, it is often confounded with them.

The consistency depends upon the duration of the process. At times it is very slight, especially during the acute stage, and naturally is not to be massaged. A short time after labor it is much better for massaging than later on, for at this time the exudate partakes of the general softening of the pelvic tissues, which are soft, slightly infiltrated, and, for a short time, the seat of an active process of absorption. Some exudates frequently disappear of themselves at this time. If you avail yourself of this opportunity everything will be favorable. When the production of fibrous tissue has taken place it is entirely different. I do not speak here of the formation of adhesions, properly so called, for these are the direct

results of perimetritis. The exudate may undergo a secondary retraction, and form a compact, hard mass, comparable to those of old cicatrices. These alterations may extend to the broad ligaments on both sides, which goes without saying, and produce displacements of the uterus, which can readily be explained, as I shall have occasion to show.

The shape, seat and consistency are modified by the treatment. These changes enable us sometimes to discover conditions which have escaped our previous examinations.

Cases L and LI are interesting and instructive in this connection. In the former, I found on examination a very firm and large exudate, the size of a fist, in the posterior portion of the right broad ligament. The uterus measured 8 cm., was freely movable and in retroversion. The cervix was large, elongated and conical. Massage soon produced marked improvement. After the exudate diminished in size it was discovered that a nucleus existed harder than the rest, and that this nucleus was attached to the uterus by a large pedicle. Local examination revealed the following conditions: The uterus was slightly deviated toward the right, and attached to the pelvic wall by retracted inflammatory remains. A large fibroid, the size of a hen's egg, and forming a part of the exudate, was found attached to the uterine wall by a large pedicle.

The use of massage in the treatment of parametritis brings up many questions whose solution is necessary in order to avoid disappointments. When must massage be

commenced? What form of massage is best employed? I answer the first question as follows: The treatment must never be begun as long as there is the slightest suspicion that the acute stage of the inflammation has not subsided, as long as the patients have chills or a rise in temperature, or increased pulse rate. This rule must be invariable. Even when the acute stage has completely subsided, it is occasionally necessary to wait a while, because secondary suppuration may occur from one cause or other in the exudate.

Nobody is anxious to rupture a purulent sac and empty its contents into the peritoneal cavity. Even if this accident should not occur, it is never wise to employ a method intended to promote absorption when this absorption might spread septic infection.

I shall briefly allude to the manipulations best employed. Pétrissage, performed from the periphery toward the centre, is best for dense tumor-like exudates; for thin, extensive exudates, longer or shorter bands, more or less dense, stretching is in addition necessary. The term pétrissage must not always be taken in its literal sense. Much force must not be employed for exudates of recent origin. It is better to use gentle, steady friction, avoiding any sudden movements, so as not to tear anything nor expose the patient to an acute attack, which will renew the disease. When, on the contrary, you have to deal with cord-like adhesions, more or less hard, and occasionally as large as a goose quill, or when you have to deal with true cicatrices, which is especially the case with the large ligaments, a great deal of force must be employed,

and you must massage with the arm extended, pressing as hard as possible. At times you may perform massage for weeks without tiring. It is fortunate, in these latter cases, when you do not have to exert deep pressure through the abdominal wall. This deep pressure is only necessary when a large part of the exudate has been absorbed and when the deeper portions of the exudate alone persist. At this time much improvement has taken place, the patients have become accustomed to the manipulations and you encounter less difficulties than in the beginning.

Several years ago a combination of massage with other methods was discussed. I have already mentioned my opinion of Swedish movements. I do not believe in general baths, electricity and prolonged hot irrigations, as recommended by Emmett.

Many physicians employ these exclusively, and sometimes obtain good results in recent cases. How do these act? I do not know. Perhaps by mechanical irritation on the exudate, through the medium of the vaginal wall. This would be a sort of mediate and indirect massage. On the other hand, these, and particularly the hot injections, may cause a local congestion favorable to the absorption of the exudate. They would then act similar to the menstrual flow. I have several times availed myself of these means. They are inoffensive, and I have never seen any unfavorable symptoms following them; but they never in any appreciable degree hastened the patients' improvement. This might have taken place spontaneously, as is sometimes seen in recent exudates

during the first six or eight weeks (frequently there is only œdema) and which disappear without any intervention. When dealing with such cases, with a soft circumscribed exudate, success is quickly attained and absorption promoted, when massage is limited to this area. The recovery takes place more quickly than with any other method, sometimes in a few days. If, however, you have to deal with fibrous exudates or cicatricial-like tissues, neither baths nor injections will produce any effect. It is then necessary to resort to prolonged and energetic massage with stretching.

Massage ought to be better understood by the medical profession, and then the organized exsndates which may even go so far as to produce cartilage like hard strings could be prevented.

It might be said without fear of contradiction that when once this connective tissue has retracted and when, in consequence, no absorption can take place, all remedies for this purpose, such as ichthyol,[1] dry cotton tampons—these two are so very frequently employed in this country—and glycerine tampons, as neither the physician nor patient is aware of, can produce some effect only by pressure on the exudate; they exercise a mechanical effect, thus acting feebly on its absorption.

It seems to me that the fact that something is being done, as is so often the case in the practice of medicine,

[1]The experiments of Prof. Chrobak, performed several years ago, on a large number of patients in his clinic at Vienna, demonstrated most clearly that the results obtained with ichthyol, compared with expectant treatment, did not affect the course of the disease in any appreciable degree.

plays a most important part, and again that prejudice exists against massage, and physicians appear to be afraid either to practice it in gynecological affections or to give the public the idea that they are practicing it. Thus it is that so many physicians recommend this and that local application, to which they might add that the effect would be excellent if massage were added. For myself, I am absolutely convinced that in these cases the chief if not sole factor is massage, provided you have the courage to say so. Thus, in an article published in the spring of 1896 in "La Semaine Médicale," Dr. Reclus describes a case in which infiltrations of the broad ligament disappeared after short treatment by hot vaginal douches.

He adds that, in addition to the douches, he employed gentle massage as an adjuvant. I believe Dr. Reclus erroneously regards the employment of massage as only an accessory method of treatment. In my opinion, in these cases massage plays the most important part.

The recovery may be regarded from two standpoints, from that of the physician and that of the patient. Unfortunately, the patient's symptoms are not always a guide to the local conditions. When the patient has been completely relieved of the symptoms complained of, she regards herself cured because she no longer suffers, is gaining flesh, is able to go about and attend to her ordinary household duties without pain. However, the physician will often find to his sorrow that a portion of the inflammatory exudates persist.

Persevering patients who would rather submit to

treatment a while longer than run the risk of a return of their former complaint, no matter how slight, can be relieved permanently. I repeat here what I have already mentioned under the chapter of uterine massage. Rarely do you meet a woman who reasons thus, especially among the ordinary class of patients. Although you have explained the conditions to them, and enlightened them concerning the future, the majority will answer that the relief obtained is all they desire; they hope that the pessimistic predictions will not be fulfilled, and that they will never suffer from these symptoms again. On the other hand, in treating the adhesions or indurated areas of parametritic origin, it is not always necessary to arrive at a complete cure from an anatomical point of view. Sometimes the patients declare that they feel much better, or even that they do not suffer at all, and yet slight adhesions or a portion of the scar may remain. Try, then, to obtain as much as possible by massage.[1]

It may seem strange that I have reported so many cases of parametritis. I did so because these affections yield more easily to our treatment. Furthermore, our cases included more of this affection than of any other which were treated and controlled at St. Louis Hospital. In studying these cases, we shall also find that they vary a great deal, especially in regard to their pathological

[1]In cases where retraction of the broad ligaments has occurred, in which the fibrous bands have not completely disappeared, or where there are large, hard scars in these same ligaments, in which a part of the indurated area is subsisting and where, even after persistent long treatment, the remaining indurated areas are no longer influenced, one may with perfect justice claim a symptomatic cure, provided the subjective symptoms are gone.

anatomical condition, and on this account they may not lack interest.

OBSERVATION XXXIX.

Parametritis.—Massage.—Cure.

Mrs. C., 37 years of age, the wife of a merchant. First menstruation at age of 13; always regular; lasts two days at the most, and not accompanied by any pain. She became a widow in 1878. From this time on menstruation is irregular. She gets married again; the symptoms continue as before. At the end of 2 years, abundant metrorrhagia. This same attack recurs at shorter or longer intervals; finally the attacks of metrorrhagia are constant, so that she can no longer make out the menstrual period. Sometimes clots are expelled; at this time the patient experiences real colicky uterine pains.

Injections of perchloride of iron arrest the flow but momentarily, and yet the blood is of normal color. The patient has, of course, become very feeble, and is obliged to rest a good deal. In November, 1882, the patient begins to suffer in the left hypogastric region; but it also seems to her as if the other side were affected. Chills, fever, tympanites, great sensitiveness on pressure. Injections of laudanum relieve her; later on, general baths of bran and water, or sitz baths with walnut leaves. She has to stay in bed for 6 weeks. Suffers constantly since that time; pains in the left lumbar region, radiating at times into the corresponding lower extremity, especially at the time of menstruation. When she turns about rather quickly she experiences a sensation as though her intestines were being displaced. The patient loses no more blood, or but rarely, and a very small quantity at each time. Leucorrhœa, abundant, thick, yellowish-green, especially after menstruation. This annoys her a good deal. Walks quite well, but tires out easily. After each walk the pains increase considerably. Dyspareunia. For a year, frequent desires at micturition. Appetite, good; digestion, poor. Frequent tympanites. Very nervous, sleeps poorly. The patient, who had been well nourished, has emaciated a good deal; she has lost at least 40 pounds of flesh.

In the beginning of 1884, electrolysis (constant current); since spring, 1885, vaginal douches of hot water, repeated at various times for 6 weeks; internally, iron, quinine and many other tonic and strengthening medications. In the left broad ligament, an exudate as large as an egg, pretty firm. Uterus enlarged, more than 7.5 cm. Mobility impaired; displaced posteriorly and to the left. Nothing abnormal on the right side. Virginal cervix. Although the patient was greatly emaciated, massage through the abdominal wall is almost impossible on account of its tenderness. For 3 weeks I am obliged to resort to preparatory massage. In the abdominal wall itself there are two indurations of the size of a hazel nut. By persisting, however, I am able to massage by this route at the end of 14 days. I apply massage for 3 months, without any inter-

ruption except when the patient suffered from an attack of influenza which lasted 2 weeks.

Exudation absorbed; uterus freely movable, diminished in size (7 cm.). During the entire treatment the patient suffered but one single loss of blood. Leucorrhœa is less. No more pains in the back; dysmenorrhœa absent at the last menstruation. Takes long walks without fatiguing. Appetite and sleep satisfactory. Treatment was begun on February 12 and finished on April 6, 1886. I heard from the patient in March, 1888, that improvement had been permanent. She has gained 25 pounds since treatment was stopped.

OBSERVATION XL.

Double Parametritis.—Massage.—Cure.

Mrs. A., 22 years of age, charwoman, began to menstruate at 13 years of age; the periods lasted 2 or 3 days. Married 4 years ago; immediately infected with lues by her husband. Treated and cured at St. Louis Hospital; no pregnancy; was always well until 1887. At that time, while menstruating, and while bending over to wash some linen, she suddenly experienced a very sharp pain in the lower part of the abdomen; could hardly get on her feet again. She was at once obliged to take to her bed. Violent chills; high fever; distended abdomen, very sensitive to the touch; vomiting; impossible for her to stir in bed. Very sharp, constant pains, especially on the left side; cataplasms, enemata containing laudanum, mercurial inunctions; was only able to get up at the end of a month. Since this time, pain on the left side; it seems to her as if something were being twisted in her abdomen. The pain, which in the beginning was almost constant, is now only present on walking.

Pressure over this area with the hand relieves it. At the approach of each menstrual period the patient is obliged to take to her bed for 24 hours. As soon as the flow shows itself she experiences no more pain. The pain often radiates into the left thigh and the epigastric region. Constant pain in the back; frequent desires at micturition; the urine often shows sediment; no burning sensation; the abdomen hard and tight; constipation, habitual; goes but every 3 or 4 days to the toilet if she does not take medicines; tenesmus. Dyspareunia; when she sits down she experiences a sensation of heaviness with a tendency to fall asleep. Digestion poor, frequent nausea. At the approach of menstruation, feeling of fulness in the breasts; cephalalgia. All this ceases when the flow is established. Considerable loss of flesh since a short time. Work impossible; does not sleep well at night. Uterus, somewhat enlarged, in normal position, but movable to the left and somewhat hard. On this side there is an exudation, pretty hard, separated by a groove from the uterus, occupying the greater part of the broad ligament and quite thick; not very painful to the touch. On the right side there is a smaller exudate in the broad ligament, along the lateral border of the cervix, of a finger's

breadth. This exudate is much harder than the one on the other side. Ovaries and tubes present no abnormalities. Massage very easy at the end of a week. At the end of 3 weeks' treatment the menstrual period appears. The painful phenomena which were formerly observed in the back do not show up this time. After 6 weeks' treatment not a trace of the exudate on the left side is left; on the right there remains but slight induration. Her general condition is excellent. Treatment is suspended, as it does not seem to exercise any influence on this last point of induration, above spoken of. No more pains; no losses of blood. The patient is able to walk a good deal and climb the stairs without feeling fatigued. The tendency to sleep which she formerly complained of exists no longer. The abdomen is soft, no flatulency; evacuations of the bowels every second day without enemata.

Cephalalgia, insignificant and easily bearable. No more dyspareunia. Appetite, excellent; digestion, good; is putting on flesh and able to work again. Treatment was begun in May, 1890, at St. Louis Hospital and stopped on June 28 of the same year. I saw her again in October, 1891. She has regained her strength and is now able to work as before her illness.

OBSERVATION XLI.

Parametritis.—Retroflexion.—Massage.—Improvement.

Mrs. L., 29 years of age. First menstruation at 16. Always slight dysmenorrhœa. Period usually lasts 5 days. Leucorrhœa, fluid, like the white of an egg. Robust. Got married at the age of 17; pregnant at 20, followed by normal confinement at term. Second pregnancy 2 years ago, terminated by a hard labor. It was necessary to extract the placenta from the uterus with the hand; the following day, chills and fever; abdomen tender, painful on pressure; pains were very sharp and violent. Ice cold compresses, painting the abdomen with collodion, and morphine injections. Was able to leave her bed at the end of 3 weeks; always sick since that time. Almost every day, sensations of very painful pressure in the rectum. Constant need of going to the closet. Pain is especially sharp when she walks a little fast. Relief after applying both hands to the abdomen. Has slight pain in the back at the approach of menstruation. Frequent desires at micturition, less, however, since a year. Goes to the toilet almost every day, without pains. She loses a glairy, ropy fluid, which she compares to melted glass. Sensation as though her limbs were breaking. Walking fatigues her very soon; she is reduced to nothing. Tympanites. Inability to tend to her work closely. Appetite poor, has to force herself to eat. Repugnance for food, especially for meat. Palpitation of the heart, sensations of tightness across the chest; gets crying spells on the slightest provocation; she always finds herself miserable. Three years ago an ulceration of the cervix was treated by iodoform applications and by cauterization with a red hot iron.

The uterus is large, in complete retroflexion (7.50 cm.), of normal consistency, attached to the rectum by an exudate, which is rather thin

and soft, extending so far as to fix it below the isthmus; the left tube is somewhat swollen, but there are no signs of fluctuation. Ovaries normal, displaced downward in the posterior cul-de-sac; they are difficult to reach.

After 3 weeks' treatment a slight improvement is noticeable. The first menstrual periods were decidedly less painful than those preceding. When the patient returned for treatment, after the end of the second menstrual period, I found, to my surprise, that the uterus had changed its place and entered the pelvis; it seemed to have completely regained its mobility in all directions. No more exudate. It is still a little larger than normally. As the leucorrhœa, although diminished in quantity, continues, I massage only the uterus. After 5 weeks it had almost returned to its original size; the tube has become normal. On June 26, 1891, her general condition had markedly improved. Her looks were bright and general condition satisfactory. The treatment in St. Louis Hospital had lasted for 2½ months. She experienced only a slight pressure in the rectum at the time of her last menstruation. She could take long walks without experiencing pain or fatigue. Digestion satisfactory. The whitish discharge became thick, colloid and greatly diminished. The uterus remained in the indicated position. Hysterical attacks persist, but lighter than before. At the end of November improvement had kept on, and her nervous symptoms had lessened; in fact, become insignificant.

OBSERVATION XLII.

Chronic Parametritis.—Retroflexion.—Massage.—Cure.

Mrs. M., 26 years of age. First menstruation at 15, always weak; constant leucorrhœa. Menstrual flow plentiful. Married since 3½ years. Confinement 3 years ago, forceps used; eclamptic seizures at the time. Fifteen months later, a second confinement, also forceps case. Since her first confinement she has always had pains in the back, extending from between the shoulder blades toward the groins; they were sharp, lancinating pains. Leucorrhœa abundant; discharge yellowish and sometimes thicker than at other times. At these times the pains were more intense. At times the discharge resembled the white of an egg. Great weakness in the limbs. Constipation, constant; a sensation as though she had to go to the toilet. These symptoms increased after the second confinement. Moreover, after each menstrual period, there were alarming hæmorrhages. In the course of last fall the inguinal pains have become more pronounced. Their intensity is very variable, and at times they radiated to upper part of the abdomen. The pains increase shortly before the time of menstruation, but they only keep on as long as menstruation lasts. Since a few months the patient has been obliged to remain in bed. For the last 6 months she has no movement without rectal injections. Colic and diarrhœa. Gets tired very soon,

and climbs stairs with difficulty. Pulse feeble; buzzing in the ears so marked that she was prevented from sleeping for some time. She is very nervous, has frequent palpitations of the heart, trembles without any provocation for several hours. Dyspnœa on the slightest cause. For several months it is impossible for her to take care of her household. Was treated for several weeks in a special clinic with electricity without any result. Her condition seemed to be even more aggravated.

Treatment began on April 7, 1891. Length of uterus almost 8 cm.; its consistency normal; retroflexion. Exudate, large and pretty firm, situated in Douglas's cul-de-sac. This exudate, which extends to the isthmus and lateral walls of the pelvis, is very sensitive to the touch. It seemed to compress the rectum, the diameter of which is diminished at this point. On the posterior cervical lip, a small ulceration, which bleeds on the slightest touch. Nothing in the adnexa.

The exudate could only be reached through the rectal route. The patient bears massage very well and feels stronger after a short time. Twelve days after the beginning of the treatment she was able to walk three hours without much fatigue.

Two weeks later, the menstrual epoch; easier than formerly. This time she was completely surprised by the appearance of her menstruation. Former constipation has improved; since the end of April defecation was regular and without pain. Leucorrhœa diminished; no more nervous excitement; no more palpitations or nervous and dyspnœic attacks. Climbs stairs without the least pain; general appearance splendid. On May 22 the exudate has disappeared, and the uterus has become movable. A slight catarrhal inflammation is left. In order to remove the cause of this I resort to massage of the uterus through the abdominal wall, which is flabby and not very thick. At the end of 30 days the uterus had remarkably diminished in size; its consistency is less firm; the ulceration is cured. This patient presented herself again in 1892, on January 8, at M. Péan's clinic. Her condition remained excellent since the end of treatment. She can without difficulty tend to her household duties. Since 3 months the leucorrhœal discharge has increased, especially at the time of menstruation. The uterus, which the evening before the day I presented her at the clinic was in retroflexion, was on that very day in anteflexion.

OBSERVATION XLIII.

Chronic Parametritis.—Resisting Band in the Left Lig. Latum.—Violent Migraines at the Time of Menstruation.—Massage.—Improvement.

Mrs. B., 27 years of age, came under my treatment while I was stopping for the first time at Ragatz, in 1886. This patient is the mother of two children, the younger one of which is to-day 3 years of age. After her second confinement she suffered from serious puerperal symptoms, followed by a protracted convalescence. She was already

suffering after her first confinement, but after her second one she suffered still more. The pains reached such a stage that she was no longer able to attend to her occupation, especially as her calling obliged her to be on her feet the greater part of the day. This patient was treated by a midwife and by several physicians; vaginal tampons of alum, cauterization of the cervix, abdominal belts, Hodge's pessaries. The latter gave her only slight relief. The patient is feeble and anæmic, and presents a cadaverous appearance. There is redness about the vulva, accompanied by pruritus. Menstruation is irregular; at times there is an intermission for two consecutive periods. Just before menstruation comes on she complains of dull pains in the groin. These cease, however, as soon as the flow of blood is established. This patient has likewise suffered from a frequent desire at micturition. Her appetite is good, but digestion is slow. Distention of the abdomen, lasting from 2 to 5 hours after meals. Her expression is habitually that of a melancholic; there is a tendency to syncope. What annoys her most is a migraine having its seat on the left side. This occurs at the time of her menstruation. It is an attack of true migraine, which does not stop until after repeated attacks of vomiting. The patient is obliged to enjoin absolute rest in bed for 2 days. Various treatments have been resorted to. Aconitine, tablets of caffeine, etc. None of these remedies produced any marked or permanent effect.

On bimanual examination it is found that the uterus is flabby, somewhat drawn over to the left side by a resisting band in the left broad ligament, seated close to the cervix, from which it is separated only through a little furrow, painful only on strong pressure. Lateral displacement to the right is somewhat impaired by the above mentioned band. Neither ulcerations nor excoriations. The tip of the finger can be introduced into the canal for a certain length. By massage it is easy to grasp the body of the uterus externally on account of the slight thickness and the flaccidity of the parietal walls. After 3 weeks' treatment menstruation sets in.

The symptoms previously mentioned have been markedly less severe than at the last menstrual period. The patient declares that never since she fell sick has menstruation been so bearable. The habitual premonitory symptoms have entirely disappeared. As to the attacks of migraine, they no longer present the same violent character as before. The patient is lively and does not tire out so easily as formerly. Digestion is good, distention of the abdomen has diminished; she is putting on flesh and gaining strength. The uterus has resumed its normal consistency, the new band above referred to has disappeared. The treatment extended over 2 months, during which the patient had 45 séances of massage. I saw this patient again at the end of a year, and was informed by her that the attacks of migraine had been checked and that her general condition was very satisfactory.

OBSERVATION XLIV.

Parametritis on the Left Side.—Retroflexion and Left Lateral Version.—Massage.—Disappearance of the Exudate.—Cure of the Symptoms.

Mrs. D., 38 years of age, has 6 children. The last confinement 2½ years ago. Up to that time she had not experienced anything that would attract her attention to the pelvic organs. Confinement at full term and regular. Two months later, menorrhagias, then metrorrhagias. Curettage of the uterus; the next day, chills and fever; still later, sharp pains in the hypogastrium and a sensation of pressure in the rectum. For 3 months no more uterine hæmorrhages. Then they reappear more profusely than ever. They are checked by injections of very hot water. Pain in the back, especially on the right side. Shooting pains in the hypogastrium during walking; the joltings of a carriage are unbearable. Sitting posture very painful; she is obliged to sit down very slowly, and on one side only. Since April, 1891, the metrorrhagias have stopped. She was treated in the hospital; laparotomy is proposed to her, but she refuses. She enters St. Louis Hospital (the service of M. Péan) in the latter days of June, 1891. As I was about to start for Ragatz, M. Péan asked her to come back on my return, in the beginning of October. On the 3d of this month we found the following condition:

Uterus slightly enlarged in size and of a relatively soft consistence; the exudate is quite large, flattened off, and of a doughy consistency; it is hard to make out its superior limit; it seems to extend as far as the fundus of the uterus, which is in retroflexion, drawn downward and to the left, and very slightly movable. Nothing in the adnexa. Besides the symptoms mentioned, the patient experiences violent pains each time she goes to the closet; she has a movement of the bowels every second or third day. Frequent desires at micturition (10 to 12 times a day). Urination is accompanied by a burning sensation. The urine does not contain any sediment. Walking is painful and tires her out quickly. The patient suffers a good deal of pain at the extremity of the coccyx. Pressure on this point elicits no pain.

Massage through the abdominal wall and through the rectum. Well borne, although at the end of some time few indurated points form in the abdominal wall. After 10 days' treatment the coccygeal pain has diminished to such a degree as to enable the patient to ride in an omnibus for quite a distance without experiencing any pain, whereas formerly the slightest jolting provoked violent pains in this region. Defecation less painful. Since 2 weeks, daily normal movements. Re-examined at the clinic on December 13, 1891. Five to six micturitions a day, not painful; does not tire out so easily. Uterus is found to be less hard on palpitation and movable; no trace of the exudate. Retroflexion and persistent left lateral version. I heard from her on January 13 last that her improvement had kept up.

OBSERVATION XLV.

Parametritis.—Retroversion.—Massage.—Improvement.

Mrs. O. M., 23 years old. Chloroanæmic. First menstruation at the age of 16. Not much of a white leucorrhœal discharge. Married at 20. Delivered the following year. Five years later, general lassitude; pain in the loins; distension of the abdomen after meals; increase of leucorrhœal discharge. Œdema of the legs. One day, while menstruating and while working at the sewing machine for a long time, she was taken sick with chills, fever and nausea. Stayed in bed a fortnight. Very sharp hypogastric pains. Cataplasms saturated with laudanum. Since that time she is suffering constantly. Hypogastric pain noticeably increased on walking and on sudden and quick movements; pains on both sides, especially on the left side, radiating into the legs. Injections of tannin. Pain at the menstrual period. Frequent urination (10 to 12 times a day); impossible for her to use the machine. Complaints of weakness. Shortness of breath on walking up stairs. Symptoms of nervous irritability, palpitation. Orifice of the uterine neck partly open; bleeds easily when touched. Ulceration, confined to the upper lip of the uterus; the latter is a little increased in size, of normal consistency and retroverted. Slightly movable, pushed to left by a large but not very hard exudate. It is of irregular shape, very sensitive to the touch, and seated in the right broad ligament.

The treatment lasted rather long before any results were produced. The exudate disappeared to a great extent. Then two hard, tendonous cords, separated by a thumb's breadth, were discovered. The cords diverge, and as they do so they seem to get smaller and are directed toward the lateral parts of the pelvis in starting from the edges of the uterus. One of them appears to be as large as a probe, the other as large as a style; both are very sensitive to pressure. After 2 months treatment nothing but a small induration remained in the outer part of the broad ligament. This induration was not sensitive to the touch. The uterus is movable, easily displaced to the left, but has a tendency of returning at once to the right; ulceration healed without further treatment. No more dysmenorrhœa or frequent urination; leucorrhœa very slight, and only after the menstrual period. Less nervous excitation. The treatment, begun on April 9, 1890, was completed on June 20. The patient was shown at the clinic of Péan at that time. In October, 1891, same state of health.

OBSERVATION XLVI.

Old Parametritis (Exudate in Douglas's Cul-de-sac).—Retroversion of the Uterus.—Massage.—Cure.

Mrs. C., 33 years of age, from Montluçon (Allier). Menstruation regular up to the time of marriage (married at age of 16). Since that time the quantity of blood has always been very small. Menstruation lasts 2 days; sometimes she has seen no sign of blood for several

months. Never pregnant. Experiences from time to time since 10 years pains in the lower part of the abdomen. Two years ago, after dancing for a long time, she was seized by violent pains in the left side of the hypogastric region, accompanied by fever. She was obliged to remain in bed for 6 weeks. At the next menstrual period, similar symptoms, but decidedly less severe. Since then she has been suffering almost every day. Pain in the left side, especially at the time of menstruation. This pain was so violent that the patient was obliged to remain in bed each time for several days. Sensation of pressure in the hypogastric region, which annoys her a good deal in walking. Slight leucorrhœa; the discharge more abundant after menstruation. Habitual constipation; an evacuation only every fourth day. Defecation very painful. It is difficult for her to ride in a carriage, so painful are the tossings. She can walk, but gets tired very easily; the upright position is equally as painful; her expression is downhearted, her general condition not satisfactory.

Uterus of a firm consistency (more than 7 cm.). Retroversion. The uterus is immovable, deviates somewhat to the left, and this is probably because of the traction exerted upon it by an inflammatory cord in the broad ligament on that side. In Douglas's pouch I found, especially on the left, a resisting area very painful to the touch. The induration extends behind the posterior vaginal wall for 2 cm. up to the recto-vaginal fold and is prolonged in the shape of a diffuse infiltration into the posterior part of the left broad ligament. Finally, another portion, pretty thin, extends from this ligament toward the sacrum along the pelvic wall.

The uterus is fixed on the left and behind. Commenced massage on March 4, 1890, and followed it up without any interruption, except at the menstrual periods, till May 5. On May 9, when examined by Dr. Péan, the patient was in the following condition:

Uterus quite movable; still in retroflexion and deviated to the left; length, 7 cm. Slight remains of the inflammatory cord, but this is stretched a good deal; the exudates in Douglas's pouch and in the broad ligament have disappeared; likewise the indurated area along the pelvic wall. In this case massage and tension are performed through the abdominal wall and by way of the rectum. Her general appearance is better and her strength has returned. Experiences no more pains in the right side, although she tires out quickly. The pains are slight. At the last period all symptoms have disappeared; she can walk without any difficulty. Evacuates her bowels almost every day without pains. Her leucorrhœa has almost ceased. This patient wrote to me in December, 1891, that the cure had been maintained.

OBSERVATION XLVII.

Chronic Double Parametritis.—Uterine Retroversion.—Not Pregnant for Five Years.—Massage.—Cure.

Mrs. M., milliner, 27 years of age. Was always in good health

until 1883. Two pregnancies terminated normally at full term. On July 14, 1885, an abortion with profuse metrorrhagia; four days later, chills and fever. Symptoms of pelvic peritonitis. Injections of laudanum, injections of hot water four times daily; improvement. Suffered from leucorrhœa, which, though it had become less abundant, still continued. Six weeks after leaving her bed menstruation showed up again. Digestion is bad; constipation, slight; she has emaciated a great deal. Walking is difficult; is obliged to bend forward in walking; suffers less when the abdomen is supported; tires out very easily. Three vesicatories, one in the middle of the abdomen and two on the sides. I saw this patient for the first time on January 17, 1890. The uterus measures 7.5 cm., of a soft consistency, drawn and fixed posteriorly (retroversion) and a little to the left by inflammatory bands difficult to reach arising in the thickness of the broad ligaments. These are considerably shortened, especially the left one; the ovaries appear to be free. The right tube seems a trifle thickened, is painful and slightly twisted.

Massage is very difficult, especially on the left, in consequence of the deep situation of the inflammatory deposit; this is also pretty painful, but the patient bears it without much complaint. At the end of 6 weeks the right broad ligament is pretty free, whereas the left one leaves much to be desired. The uterus is more freely movable than before. The patient stops treatment for 2 months. When she returns I find her in about the same condition as at the time of interruption. I continue the treatment for 5 weeks; the uterus has now become movable to a large extent. The fundus may be considerably displaced forward and brought underneath the promontory, but returns to its malposition when released. Diminution in size (7 cm.). The right tube is a trifle less in size than it was, but not quite normal. Still slight retraction of the left broad ligament. Her general condition is excellent. Not the slightest pains at the last two menstrual periods. She loses no more blood; the discharge, which at first had the consistency and appearance of the white of an egg, has now become thicker and more yellowish, decreased in quantity. Micturition no longer painful. Appetite good; digestion good. Left the hospital on May 23, 1890. She was well. I learned that she got pregnant 3 months after she left.

OBSERVATION XLVIII.

Chronic Parametritis on the Left Side.—Ovaritis and Perimetritis on the Right Side.—Massage.—Improvement.

Mrs. B., 39 years of age, mother of 5 children. An abortion, 6 years ago, followed by very grave symptoms. Since 5 or 6 years, profuse hæmorrhages; menstruation lasts from 8 to 10 days, instead of from 3 to 4, so that after each menstruation she feels so exhausted as to be hardly able to keep on her feet. For 2 years, shooting pains on the right side, and from time to time also on the left side. The pain is more of a dull character on this side than on the other; sometimes,

especially after the menstrual periods, she has slight rectal pains. Obstinate constipation for several years; movements of the bowels painful; leucorrhœa; injections of tannin solutions without result. Six months ago, amputation of the cervix. The menstrual period following this operation profuse, whereas the next periods are less profuse and not painful; they last from 4 to 5 days. Complete retroflexion. The uterus is adherent on the right side and behind by several inflammatory bands, very sensitive to the touch and forming thin cords which extend from the margins of the uterus to the lateral and posterior surfaces of the pelvis. There is an infiltration at the base of the left broad ligament. The left ovary is very large, sensitive to the touch, displaced into the posterior cul-de-sac, to which it is attached by a very thin band.

Massage through the abdominal wall is very difficult, on account of tenderness, stretching of the cords through the vaginal route. From time to time I am obliged to suspend the treatment for a day or two in order to give the patient time to recover from the general irritation produced. She complains at times during the séances of a very painful sensation of pressure in the rectum. Tension through the rectal and abdominal route in order to loosen the left ovary; this is a very difficult task. Treatment was begun in the St. Louis Hospital on November 12, 1890, and stopped on January 30, 1891.

The patient is completely cured, so far as her symptoms are concerned; she has not felt the slightest pain at the last two menstrual epochs, and is able to walk without difficulty. No more constipation. An acne eruption of the face which she has had for the last 3 or 4 years is on the point of disappearing. No cords, no infiltrations. The uterus is freely movable, its size seems also to have diminished; remains now behind the pubic symphysis, but it resumes at once its former malposition. Persistent retroflexion. I do succeed under great difficulty in stretching the adhesions of the left ovary; the tenderness has disappeared and the size diminished. I heard from this patient toward the end of June. Leucorrhœa slight, regular, easy daily movements. Improvement has been steady. This patient showed herself at the clinic on January 15, 1892. Improvement remained.

OBSERVATION XLIX.

Parametritis Dextra.—Salpingitis and Ovaritis Sin. (Gonorrhoic Origin?).—Massage.—Cure.

Mrs. A., 28 years of age, laundress. Four years ago, blenorrhagia; discharge thick, yellowish and profuse. As the result of this, distension of the abdomen and pain so that she could not even bear the contact of the hand. Gradual improvement. Since that time she has always had, at the time of menstruation, distension and hyperæsthesia of the abdomen. Sharp pains during urination. At the end of 2 months, chills, fever and violent hypogastric pain. The patient is obliged to remain

in bed for 5 weeks; since that time the abdominal pain on the right side has been almost constant. It seems to her as if she had a foreign body, with a tendency to drop down. These symptoms are more pronounced and painful at the time of menstruation; she experiences also at this time a pretty sharp pain in the left ovary; she has to stay in bed; she obtains relief from the application of a hot water bag. The menstrual periods appear earlier; dyspareunia so painful that sexual intercourse is almost impossible. Digestion is good; the patient has gained flesh and presents a healthy appearance. Injections of a decoction of oaktree bark; tampons of alum; the discharge has considerably diminished and assumed a whitish color. Micturition is not so painful any more; the other sensitive local points have not changed in the least. In the course of last summer, applications of vesicatories on the right side, improvement for two weeks; but the symptoms returned very soon; gonococci in the leucorrhœal discharge.

On bimanual examination I find on the right side a parametritis with an exudate as large as a walnut situated near the margin of the uterus at the base of the broad ligament; it is resisting and very sensitive on pressure. Posteriorly the exudate is especially hard to the touch. This can be easily detected through the rectum. The uterus immovable, inclining towards the right and somewhat increased in size (virginal cervix). The left ovary, situated deep in the pelvis, is sensitive on pressure and larger than normally; the corresponding tube shows the same characteristics as the ovary; the former does not seem to contain any liquid. Tube and ovary can without difficulty, but only for a moment, be brought into their normal position. As the abdominal walls are quite soft, exploration and massage can be conducted without causing much pain. Massage can also be performed through the rectum. It is the exudate on the right side which was especially rebellious on account of its great size and hard consistency; treatment lasted 10 weeks. The uterus has completely regained its mobility. The left ovary and tube have decreased in size as well as sensitiveness, but they are still displaced. Her general condition is satisfactory; since a fortnight the patient suffers no more; the last menstrual period was not more painful than when the patient became ill, 3 or 4 years ago. Movements almost every day. No more dyspareunia; slight whitish discharge. This patient was presented at the St. Louis Hospital on February 28, 1890. Since then she has left Paris and nothing more has been heard of her.

OBSERVATION L.

Small Subserous Fibroma.—Chronic Parametritis on the Right Side.—Massage.—Disappearance of Symptoms.

Mrs. W., 32 years of age, a nurse. Never pregnant. Since 5 or 6 years, indefinite pains in both sides of the abdomen. Eighteen months ago (the day after sexual intercourse) she suffered from pretty sharp pain on the right side; this has since persisted, although with less

intensity. If she takes a long walk she complains of a dragging sensation and very severe pains in the abdomen. Sexual intercourse is followed by lancinating pains in the right side which the patient compares to those felt in a furuncle that is about to open. Strong pressure over the area affected diminishes the pain. The painful attack lasts usually 24 hours. Since a few months, pains in the back; dysmenorrhœa; the abdomen is distended and assumes the shape of a pear at the time of menstruation. Urinates up to 20 times during the day, nights are quiet. It is impossible for her to wear a pessary.

On vaginal examination I find deep in the pelvis and pretty high up on the right side a tumor of a very firm consistency and of the size of one's fist, apparently forming one mass with the uterus. Uterus large (8 cm.), harder than usually; it is slightly movable and in retroversion; the cervix is long and cylindrical. Massage poorly tolerated; the patient complains of a sensation similar to that which is produced by pressure on the bladder. In spite of this, she soon bears it better. Three weeks after the beginning of the treatment the dysmenorrhœa has already diminished a good deal. After the diminution of the tumor, I found that a large parametric exudate had developed around a nucleus harder than the rest, a fibrous body, of the size of a walnut and attached to the uterus by a large base. Treatment began on November 26, 1890; she was presented at Dr. de Péan's clinic on January 16, 1891. Pains, slight and bearable, produced in all probability by the fibrous tumor; no more exudate; her general health much better than before. Walking does not annoy her very much; tends to her household pretty well. Uterus freely movable.

OBSERVATION LI.

Left Parametritis and Salpingitis.—Parametritis and Uterine Fibroid on the Right Side.—Massage.—Partial Disappearance of the Affections.

Mrs. L., 41 years of age, of Noisy-le-Sec. Had never been pregnant. Menstruation generally regular, lasting 4 or 5 days. Fifteen at first menstruation. Twenty years ago, cauterization of the uterus for an affection having as its principal symptom a leucorrhœal discharge which was yellowish, thick and abundant, probably of blenorrhagic nature. In the course of the treatment she experienced one day violent and sudden pain in the abdomen, accompanied by chills and fever; abdomen distended, very sensitive to pressure, vomiting; cataplasms, injections of a decoction of marshmallow, vesicatories at different times. She stayed in bed for 3 months. After getting up again, applications of tincture of iodine for 6 months. Sitz baths. Her condition improves gradually, but does not recover completely. After a rather long walk she is obliged to stay in bed, on account of great fatigue; she complained of hypogastric and abdominal pains. These latter especially on the right side. She is unable to assume the erect posture for any length of time. She experiences a sensation of pressure downward and to the right, as if a bar were pressing on her abdomen;

frequent urination. Menstruation is regular, almost no whitish discharge, containing no gonococci; dysmenorrhœa; pain in the loins; shooting pain in the right hypogastric region; obstinate constipation. No action of the bowels without enemata. For a number of years has gone to several clinics. Various treatments followed, without much benefit; different internal as well as external treatments resulted in temporary relief. I saw the patient for the first time in 1890, at the clinic of Dr. Péan.

Examination was difficult because of her corpulency. Uterus of abnormal size (9 cm.), firmer than in normal conditions and retroverted. On examination by the rectum it is found that the uterus is enclosed between two hard tumors, the larger one of which almost completely fills the left half of the small pelvis, compresses the rectum and extends backward as far as the sacrum. It does, however, not seem to be fixed to it. On bimanual examination we find that it reaches as high as iliac crest; the ovaries and the left tube seem to be included in this tumor. The uterine body is separated from it by a small furrow. The tumor on the right side is of the size of one's fist. The swelling on the right side was exclusively formed by a fibroid, while on the left the tumor seemed to be of a more complicated nature. After 6 or 7 weeks' massage the external portions, consisting of inflammatory tissues, having disappeared, it was easy to make out the tube and ovary.[1] This tube had increased in size and had become as thick as a thumb. I could distinctly feel that it contained some fluid. The uterus had become almost detached from the tumor and partly movable. The ovary was fixed to the tube by a thin adhesion. I succeeded in freeing it by stretching. I did not think it wise to continue massage of the tube, for fear of rupturing it, and also because the patient no longer felt the slightest pain on the left side. On the right side, corresponding to the fibrous tumor, she still complained of pain from time to time. The bowels are regular. Her general state of health had improved considerably. She came to the clinic on April 10, 1890. In December of the same year she was in the same state of health as at the end of treatment.

OBSERVATION LII.

Parametritis. — Salpingitis. — Left Periovaritis. — Massage. — Cure of the Symptoms.

Mrs. L., 32 years old, laundress. She has never been pregnant. Four years ago, after sudden exertion, she felt violent pains in the loins and the abdomen. Fever, chills, swelling and tenderness of the abdomen. She stayed in bed more than a month and could not resume her work until several weeks later. Constant pain, more acute when

[1] Owing to the great size of the tumor, I at first massaged it very energetically through the abdomen with both hands. Later on, when the tumor had diminished in size, I employed the bimanual method.

fatigued; pains in the loins and the groins. Sensation of heaviness in the abdomen and sudden, sharp pain; tenesmus. Dragging sensation in the anus. Frequent urination, especially during the menses. Habitual constipation. She sometimes remains 2 or 3 days without any movement. Constipation alternates with diarrhœa. Dyspareunia, such that for a long time sexual intercourse was impossible. Cauterization (Pacquelin) and internal medications without any results. At the beginning of November, 1889, she suddenly experienced pains in the loins while carrying a large bundle of linen to the laundry. She then had her menses. This pain was so violent that she had to drop her linen, be brought home in a carriage and be immediately put to bed. Constant pain in the form of colic in the loins; abdomen sensitive to pressure. Poultices saturated with laudanum. Having been treated at home for some time without any results, she sought admission into the St. Louis Hospital (M. Péan's clinic). This was the time when I first saw her, on January 10, 1890.

Besides the symptoms referred to above, she complains of violent pains in the right hypogastric region. She is very weak. Uterus retroflexed, voluminous, soft and sensitive to the touch; cervix virginal. Impossible to impart the slightest movement to it. It is fixed by a large exudate and very painful to pressure. This exudate reveals to the touch a sensation of resistance in the pouch of Douglas. The left tube is distended and of the size of one's index finger. Along its outer extremity it is firmly adherent to the anterior abdominal wall (old inflammatory adhesions). On the right side, periovaritis. Massage by the rectal route very painful at the beginning; tenderness diminished by the administration of belladonna suppositories. After 7 weeks' treatment the inflammatory products have disappeared and the uterus has become quite movable, but its malposition still remains the same. The uterus is considerably smaller, has become more resistant and is no longer sensitive to the touch. The periovaritis has been overcome after 3 weeks' very gentle massaging by the bimanual method, i. e., recto-abdominal. It did not seem possible to touch the tubal adhesions, so thick and rigid did they appear. I feared to cause a rupture by massage and stretching. On February 28, 1890, all the syptoms she complained of have disappeared. No pains in the left side or in the loins, regular daily movements; no difficulty in walking; no dyspareunia. In March, 1892, I showed her again at the St. Louis Hospital. She declared that she had no complaint since she left the hospital, more than two years ago.

CHAPTER XI.

Perimetritis.

Its Rarity.—Tendency to Produce Adhesions.—Results Less Satisfactory Than in Parametritis.—Accidents, Only Slight.—Cases.

Massage may be useful in these affections if it is not contraindicated, but I must qualify this statement by saying that its results are not as satisfactory as in parametritis. Perimetritis always has a tendency to form new tissue, and adhesions remain after the acute stage has passed. Adhesions of the tubes to the ovaries, adhesions of the tubes and uterus to the intestines, to the pelvic walls, to the bladder, etc., often result.

It appears difficult at first sight to imagine how a perimetritic exudate could form in front of the cervix. At a certain stage this exudate is soft, and under the influence of its own weight it descends, and collects in Douglas's pouch. I have never met with precervical parametritis. Its rarity is explained by the fact that the space between the cervix and bladder contains very little connective tissue. But the inflammation is not limited to this area, but invades the serous coat and thus forms the adhesions.

Lesions of this kind are more frequent behind the uterus and vagina. Authors are far from agreeing as to

the origin and precise location. Most believe that the inflammation arises in the peritoneum. My personal experience is not in accord with this. Retro-cervical perimetritis is not so frequent as is ordinarily supposed, and I believe that it is frequently confounded with intra-peritoneal exudates.

It seems paradoxical to speak of the apparent rarity and the real frequency of perimetritis. There are less cases reported in this chapter than in the previous one. The patients affected with perimetritis who came under my care at the St. Louis hospital were less numerous than those affected with parametritis. Clinicians and pathologists are unanimous in the belief that adhesions due to local peritonitis of the pelvic organs are more frequent than is generally supposed. They are often found at autopsy in patients who have died of other affections than those of the pelvic organs, and who never complained of symptoms referable to these adhesions. From this it can be inferred that adhesions due to slight perimetritis are usually well borne.

The occlusion of the abdominal opening of the tube as a result of a localized inflammation is too well known to detain us here. That this occlusion may give rise to a salpingitis or a salpingo-ovaritis, as is usually the case, matters little.

Accurate diagnosis, as in all periuterine affections, is not always possible at the first séance. There may exist physical obstacles preventing us from arriving at the proper diagnosis. This may happen to the most experienced diagnostician, even if he is well versed in pelvic

massage. We ought not to be discouraged at this. By perseverance you will almost always be successful in a few days, and not be compelled to resort to anesthesia, except in very few cases. What has been said about this applies even more aptly to perimetritis. There is regularly great tenderness in these conditions, and this constitutes a difficulty, at times quite serious, in the proper examination of the organs.

Adhesions to the intestines, tubes, bladder, etc., are sometimes present. It might be easy to loosen these by brisk manipulations, but the tearing of a portion of their walls might be the result. Great care must be used in such cases. The thicker and firmer the adhesions the greater is the care necessary. Some physicians might foolishly say that a slight rupture of a tube and emptying a small portion of serous fluid into the peritoneal cavity would be fraught with insignificant consequences, and easily repaired. The diagnosis of tubal affections has made rapid progress in the last decade, but it would be astonishing assurance and confidence in one's diagnostic ability to claim to be able to say that a dilated tube contained only an inoffensive serous fluid and no pus.[1] It would be very unwise and imprudent to stretch adhesions to almost the rupturing point.

Perimetritis terminates sometimes in cystic collections of fluid. We may repeat here what has already

[1] A continuous evening temperature and similar symptoms, which might make one suspect a suppurative salpingitis, have but relative diagnostic value.

been said about the tubes, that there is great risk of rupturing these and emptying their contents into the peritoneum, because uncertainty always must exist as to the nature of their contents. I am well aware that the rupture of these fluid sacs is not always followed by serious consequences to the patient. But in spite of this, I would never advise anybody to attempt it. I shall allude to this subject later on.

I have advised against chloroform narcosis unless it is absolutely necessary. I have previously stated my objections. Sometimes, as above mentioned, we are obliged to employ it in cases of perimetritis. The patients suffer so much on the slightest touch that it is impossible to examine them through the obdominal wall[1].

The results obtained are less satisfactory than in parametritis. In the latter we frequently obtained recovery, in the absolute sense of the word. Independently of the subjective improvement, we had complete disappearance of the exudate, which is really a return to the previous condition, a real *restitutio ad integrum.*

We must not expect that the adhesions of perimetritis will entirely disappear. If you can stretch them, render them less firm and obtain marked improvement of the local and general condition and a complete disappearance of the painful symptoms, much has been gained. In other cases it is useless to prolong the treatment, as you will accomplish nothing by it. The case then requires surgical intervention.

---

[1]I only anesthetize patients in order to make a thorough examination at the beginning of the treatment, and never subsequently.

I have stated that retrocervical parametritis is more frequent than many authors had suspected, and that it is frequently mistaken for a peritoneal exudate. When parametritis is alone, or when there is perimetritis and parametritis at the same situation, as is nearly always the case, certain rules must be followed in massaging.

The manœuvre which Brandt calls *malning* is employed. The index finger is introduced into the rectum as far as the exudate; very gentle circular frictions are then performed. If the exudate extends along the pelvic wall toward the sacrum, massage must be performed laterally, and antero-posterior movements are required. These manipulations are at first painful to the patients, but the tenderness gradually diminishes. The peripheral parts of the exudate are first absorbed. As the condition improves and the less morbid tissue remains to be massaged, the further the latter seems to remove. The manipulations become difficult and painful to the physician, and they must frequently be interrupted, occasionally several times in the course of the same séance. It is needless to remark that during this interruption the finger must remain in the rectum. It is well to support the pelvis with the free arm or by placing a cushion under the patient's hips.

OBSERVATION LIII.

Perimetritis and Periovaritis.—Massage.—Relief of Symptoms.

Mrs. S., 27 years, the wife of a manufacturer from Lille. Began to menstruate at 16. No dysmenorrhœa. This patient, of a blonde and scrofular type, has had leucorrhœal discharge from almost the time

she began to menstruate. Married at 22; got pregnant almost immediately, pregnancy terminated in a difficult labor (forceps). From this time on she had slight pains in the back and hypogastric region. Curettage of the uterus. Two days later, septic pelvic peritonitis, at first bilateral, then limited to the right side. Remained in bed for 6 weeks. Ice cold compresses, landanum injections. Since this time her health began to suffer; only rarely were her periods without pain; almost constant pains on the right side, but they also pass from time to time to the opposite side. At the menstrual periods, in case she walks pretty quickly, this pain gets sharper and radiates toward the back and rectum. From time to time, tenesmus. Micturition more frequent. The patient's bowels move every day; not much pain connected with them; before menstruation, slight diarrhœa. Leucorrhœa, a little abundant. Habitual headache; bilateral intercostal neuralgia, more pronounced on the left side, at the time of menstruation. The patient has constantly used hot vaginal douches without the slightest result. At the beginning of 1887, sojourn at Salies de Béarn; temporary improvement. The patient, who not long ago was healthy looking, is now emaciated a good deal; her complexion has assumed an earthy color. She is unable to do the slightest work in her household. I saw her for the first time in October, 1888. The patient, whose abdominal walls are pretty thin, contracts them forcibly on my first attempt to grasp the pelvic organs. After massaging the abdomen for a few minutes at every séance the pelvic organs can be seized without difficulty. Uterus retroverted; consistency almost normal; slightly deviating to the left, only slightly movable in the opposite direction. The left ovary has the size of a walnut; it is sensitive and firmly fixed by adhesions in the vicinity of the sacro-iliac articulation. The right ovary does not appear larger; on touching it sharp pains are elicited (periovaritis); it lies behind the broad ligament, but it is not bound down by adhesions. Tubes are normal. Utero-sacral folds are swollen, relaxed and sensitive to the touch. Massage, at first somewhat difficult, becomes easy at the end of a fortnight.

Distention of the left ovarian adhesions with the greatest care. Massage through the abdominal, vaginal and rectal route. The lesions have been but slightly modified. After 7 weeks' treatment (abdominal and rectal massage) the adhesion has been slightly stretched and the uterus has become a little more movable. Impossible to reach high enough in order to be able to massage the left ovary itself. The left ovary is massaged per vaginam and abdomen; it is no longer tender on touch. The uterus, still retroverted, diminished in size. No more swelling or pain to the touch in the utero-sacral folds. The pain on the left side is completely gone. Felt but slight one at the last menstrual period. No more frequent desires at micturition. Leucorrhœa has almost entirely stopped. Appetite is excellent. Her embonpoint is returning, more ambition and better general health than she has known for a long time.

I saw this patient again in December, 1889. She enjoyed very good

health up to the end of June. At this time, slight pains during three consecutive menstrual periods; absolutely nothing in the interval. No more intercostal neuralgia, no more diarrhœa; is gaining flesh rapidly. Advices received spring 1901 inform us that her improvement remained permanent.

OBSERVATION LIV.

Perimetritis.—Oophoritis; Salpingitis.—Massage.—Improvement.

Mrs. C., 36 years of age, laundress. Four pregnancies; the first one terminated in an abortion; two others at full term, the last one 3 years ago. Eighteen months ago (July, 1885), deep mental emotion at the time of menstruation; chills, pains in the lower part of the abdomen, especially on the right side; nevertheless she remained up and about. At the end of 3 months the pain had calmed down, but did not disappear. This constant pain was at times so violent that the patient was obliged to stop in the street to catch her breath. From time to time, especially when she had taken a long walk, she experienced the peculiar sensation as if she had a movable tumor on the right side. At the time of menstruation the pains were like those in a confinement, accompanied by a very painful sensation of pressure in the rectum. The patient, who was formerly robust and strong, has emaciated considerably; her strength is less; urinates frequently, 2 to 3 time in an hour; the urine is often cloudy. No digestive disturbances, no constipation; from time to time, desires as if she had to go to stool. The weakness was so great that the patient could not follow her former occupation and had to turn to millinery. Two applications of the thermo-cautery relieved her for a little while; later on she took iron and quinine, without result. An ulcer of the cervix was cauterized.

The uterus is slightly enlarged in size, retroverted, partly movable toward the front, but it immediately resumes its malposition on releasing it; it is attached to the rectum by a very large, thin, firm and very sensitive adhesion. The right tube is dilated, of the size of the index finger; fluctuation very distinct. The left tube is not much larger than a lead pencil, but firm, and hard on pressure (Salpingitis Interstitialis). The corresponding ovary is of the size of a pigeon's egg and very sensitive to the touch; the right ovary is a little increased in size and painful.

Stretching and massage through the vaginal and rectal route and through the abdominal walls were begun in December, 1886, at the St. Louis Hospital. The condition of the walls is very favorable. At the end of 3 weeks the patient has to interrupt treatment. Her condition has somewhat improved; she claims to be able to walk better. At the end of 5 weeks massage is resumed. The uterus could only be partially freed posteriorly; the right ovary insensitive and almost of normal size; the left ovary greatly diminished in size, but still a little tender. The left tube is softer; its walls are of normal thickness. There

is still a little pain at the time of menstruation, but this pain is nothing as compared with the pain that existed previously. The sensation of a tumor has disappeared from the right side; the sensation of pressure in the rectum likewise. Leucorrhœa almost gone; it did reappear, it is true, after the last menstruation, but very slightly. The patient urinates but 5 or 6 times a day; the urine is clearer. She returns to her work. Treatment was stopped toward the end of March, 1887. I heard from her in March, 1888; since 2 months she considers herself pregnant. Improvement steady; leucorrhœa very slight in amount; experiences but slight pain, in fact almost insignificant, at the time of menstruation.

OBSERVATION LV.

Perimetritis.—Uterine Retroflexion.—Recto-uterine Adhesions.—Ovaritis.—Dysmenorrhœa.—Nervous Symptoms Local, Distant and General.—Massage, at First Through the Rectal Route; Later on, Through the Abdominal and Rectal Route.—Great Improvement.

Mrs. B., a widow, from New York, 33 years old. Toward the end of adolescence various causes brought on chlorosis. She complained of pains in the inguinal regions and leucorrhœa. She had been informed that all would disappear when she got married. Instead of the improvement she expected, her complaints were aggravated after her marriage. First pregnancy at the end of first year. Miscarriage in the third month. In 1880, new pregnancy shortly after the termination of the first; delivery difficult; the midwife has to introduce her hand into the uterus to remove the placenta. She had severe afterpains, violent fever, bad smelling lochia. Left her bed at the end of 6 weeks. For 2 months all went well; at the end of this time she suddenly felt, after sexual intercourse, a very sharp pain in the lower part of the abdomen. This disappeared after a few days. Injections containing laudanum; it is difficult to introduce the nozzle of the syringe on account of the tenderness of the parts. Since that time she has almost constantly suffered; she rarely has a day where the pains have calmed down so that she is able to tend to her household affairs. She spent one season at Kreuznach, in 1883; no improvement; injections of tannin solution and of a decoction of walnut leaves; thermocautery applied several times without result; was also curetted twice without any benefit. Can wear no abdominal bandage; no pessary. Last spring she had an ulceration of the cervix cauterized for 5 weeks and it was healed at the end of that time. I saw this patient at the beginning of the year 1885. She complains of violent pains all over the lower part of the abdomen without being able to locate them precisely. These pains radiate into the back and rectum; they are particularly sharp during the menses. There is slight improvement for a little while, then aggravation.

Habitual constipation; defecations are very painful; toward the end of menstruation, constipation habitually gives way to diarrhœa. Complains of sensation of pressure in the rectum; the slightest walk

fatigues her; on walking she usually bends forward. Leucorrhœa much less than formerly; the flow is alternately yellow and white. Migraine, intercostal neuralgia, general nervous complaints. Appetite good, digestion satisfactory.

On local examination we find a deep laceration on the left side of the cervix; on the right side an ulceration on the posterior lip. The body of the uterus lies behind in the cavity of the sacrum (retroflexion); it is completely immovable and adherent to the rectum by a thin, flat but firm band; the latter begins at the inferior border of the body, but it is difficult to make out its upper limit. The consistency of the uterus is normal; its size does not seem to be increased; mobility toward the front slight. Local sensitiveness and her nervous condition are so marked that we are obliged to chloroform the patient in order to make a more thorough examination. We obtain information confirming what had been furnished by rectal and vaginal examinations; furthermore, a displacement of both ovaries is made out. The right one is increased in size and has sunk into Douglas's cul-de-sac, where it is held by slight adhesions. The left ovary is likewise sensitive to the touch and fixed to the pelvic wall by an adhesion which is very thin; it is much larger than normally. It is almost impossible to dream of massage through the abdominal wall on account of the sensitiveness of the hypogastric region; rectal massage alone is tolerated. The index finger of the other hand is introduced into the vagina to act as support. In order to quiet the irritative phenomena I have applied for 10 days opium and belladonna suppositories. At the end of this time they are no longer necessary.

Treatment was stopped at the end of 2½ months. The uterus has become more freely movable; it can now be displaced forward, and this position seems to be maintained, but it returns to its former position and remains firmly attached to the rectum. The left ovary is free, greatly diminished in size and less sensitive to the touch. On the right side the result is less favorable. After a great deal of difficulty I succeeded in detaching the ovary from the bottom of the cul-de-sac; the adhesion has been stretched a good deal. The sensitiveness has diminished to such a degree as to allow massage to be performed through the abdominal and rectal route. Her local and general condition have become quite satisfactory. She can walk great distances without fatiguing much; walks erect. Dysmenorrhœa insignificant; did experience only slight pain at her last menstrual period. Still a little leucorrhœa; no more diarrhœa; movements regular and daily. No more headaches or intercostal neuralgia; she feels stronger than before, but always very nervous.

I saw this patient one year after the treatment, while she was passing through Paris on her way to the South. She has been feeling very well since the attack ceased. Has but rarely slight pains at the menstrual periods. Menstruation is no longer so abundant as before; a slight leucorrhœa now and then. No more nervousness; she is very well satisfied with the result obtained.

OBSERVATION LVI.

Five Years for Perimetritis. — Cords in the Broad Ligament. — Dysmenorrhœa.—Dyspareunia.—Massage.—Cure.

Mrs. M., 31 years old. In 1881, difficult labor, after which she was obliged to stay in bed for several weeks. Later on, thick leucorrhœal discharge. General uneasiness in the hypogastrium, especially on the right side; increased by pressure. In 1884 she consults a specialist, who prescribes vaginal injections with very strong solutions. Iodized plugs. Temporary improvement. Cure at Kreuznach, the following year at Franzensbad. Transitory amelioration. Violent pain during the menses; stays in bed during the whole period. After sexual intercourse, pains and occasional vomiting. I saw the patient in the spring of 1888. Uterus; its size normal; retroflexed, only slightly movable. A band starting from the upper limit of the vaginal portion of the neck and apparently tending upward and backward into the left broad ligament. It is impossible to reach its upper limit with the fingers. It is firm and sensitive on pressure. The right ovary, which is increased in size, as big as a pigeon's egg, is attached by a rather broad band to the outer part of the sacro-iliac symphysis.

Examination and massage are considerably facilitated by the thinness of the abdominal walls. After 5 weeks the uterus is a little more movable and the patient feels better. Three weeks later I only felt the lowest part of the cord. The ovary, which is smaller and less firm, is relatively free. The adhesions still remain there; they are lengthened, however, after 2 months' stretching. The malposition of the uterus remains, although this one is more movable. The patient is no longer suffering. She is delighted at the obtained result, and is ready to leave for the seaside. But before leaving I have her promise to return immediately if any symptoms should appear.

I saw her at the end of November. She declared that during the summer she had experienced almost no pain, but that for 3 weeks she did not feel so well. I continued the treatment in order to cause the disappearance of the band I referred to, because I thought that that was the cause of the partial relative relapse. Three weeks later this had almost disappeared. The uterus is of the same size and quite movable. As she still remained in Paris for 2 months, with her husband, I had the opportunity of seeing her several times. Her general state of health was excellent. During her last menstrual period she felt only slight pain on the right side; leucorrhœa insignificant; no longer any dyspareunia. I heard from her again the following May. Her state of health was the same.

OBSERVATION LVII.

Perimetritis; Salpingo-ovaritis Blennorrhagica. — Massage. — Threatening Pelvic Peritonitis.—Treatment Resumed After the Cure of This Trouble.—Marked Improvement.

Mrs. L., 30 years old, from Bordeaux, presented herself at my office on November 2, 1889. She had enjoyed good health until the time of

her marriage (September, 1883). A few weeks later she complained of a discharge, thick, yellowish-green, greatly irritating the skin. During urination she had a burning sensation; desires of urination frequent; on vaginal injections of alum solutions the pains let up somewhat; the discharge is less, but it preserves its former character. Last spring, as a result of sexual intercourse, violent pains on the right side, distention of the abdomen, vomiting, etc. She had to remain about and tend to her household affairs as well as she could. Menstruation became gradually very painful; the patient has to stay in bed as long as it lasts. Menstruation occurs ahead of time, and the discharge is more abundant than formerly. Painful sensation of pressure in the rectum, especially at the approach of menstruation. Sexual intercourse unbearable, sharp pain on the right side; in spite of all, the patient is not so much emaciated; she preserves a certain stoutness. She rather desired to be treated for those painful symptoms she suffered from than for the sterility; the latter, she was persuaded, and rightly so, was due to her local trouble. Up to this time she had been treated by vesicatories, paintings with iodine, thermocautery curettage, douches, and all this without the slightest result. Two years ago she stopped at Salies-de-Béarn; internally she took iron, quinine and arsenic. Three years ago, cauterization of a cervical ulcer; this ulceration was cured by the treatment. No urethritis, slight vaginitis. The utero-vaginal secretion contains no gonococci; this fact seems all the more surprising, as the husband, who was then being treated for a chronic urethritis, had a certain number of gonococci in the secretion. He had contracted his last gonorrhœa two years ago.

On examining the patient with a speculum I find on the posterior lip of the cervix a small ulceration which extends into the cervical canal. It seems to be superficial and bleeds a little when touched. The patient's extreme tenderness does not permit us to make a thorough examination of the genital organs without anæsthesia. The right tube is swollen and a distinct sensation of its containing a small quantity of liquid is present. Its outer portion is a little twisted; this is caused by periovaritis and its adhesion to the ovary. On the left side there also exists a slight swelling of the tube, but it does not seem to contain any fluid. The tube and the corresponding ovary are adherent to the intestine. The utero-sacral ligaments are slack, swollen and sensitive to the touch, especially on the left side. The uterus does not seem to be any larger than normally; it is freely movable and a little sensitive to the touch. As it was impossible at this time to begin pelvic massage proper, I devoted myself for 3 entire weeks exclusively to massage of the abdominal wall. I succeeded in diminishing its sensitiveness. After this preparatory massage I was able to apply a more radical procedure. I started in as gently as is possible in massage and tension; in spite of this, the treatment was pretty poorly borne. I supposed that if it really was so painful it was due to the adhesion of the tube and ovary to the intestine. On the sixth day the sensitiveness over this focus was exaggerated; the patient had even a slight rise in temperature. I stopped treatment; ordered her to bed and had her put an ice bag over the hypo-

gastric region. At the end of 48 hours all these symptoms had disappeared. Under these circumstances I began treatment again after 10 days' interruption. From this moment on the results were satisfactory. At the end of 6 or 7 weeks the adhesion to the ovary above referred to has been considerably stretched; Douglas's pouch is almost normal. Left ovary insensitive on palpation; the swelling of the tube on this side has disappeared. Both are movable, and occupy their normal place. The right tube is also a little diminished in size; it does not seem to be so tight or wrinkled. The ulcer has completely healed without any special treatment. At this moment the patient's condition is satisfactory; the discharge is almost gone; there is but a very small quantity immediately after menstruation. Four months after the end of treatment I received a letter from her, in which she apprised me of the fact that the pains had still more diminished; that menstruation had become less abundant and more regular. Intercourse no longer painful, but pains the day following the connection.

OBSERVATION LVIII.

Perimetritis and Parametritis.—Small Cicatricial Cord in the Broad Ligament.—Chronic Salpingo-ovaritis.—Different Local and General Affections.—Massage.—Cure.

Miss B., 27 years old, governess. This patient had been rather corpulent up to a few years ago, but since that time she has lost a great deal of flesh. Toward the end of adolescence, chloro-anæmic. Menstrual flow not copious; the blood is of a pale color. In 1881 the dysmenorrhœa was such that a surgeon of Paris was obliged to treat her by incision of the uterine neck (bilateral incision). This incision was followed by an aggravation of the patient's condition. Fever, chills, rigors, painful swelling of the abdomen and vomiting. After a few days the inflammation became limited to the left side. Poultices saturated with laudanum, tincture of iodine, mercurial ointment. For 3 weeks obvious improvement, but at the second menstruation following the treatment the pain returned, and so violently that she had to stay in bed 2 weeks. Since then she has never been quite well. Pain in the left side so intense that she could hardly stand up during menstruation. Blisters produced only temporary improvement. She was obliged to leave her position and return to her family. I saw her in St. Louis Hospital clinic in December, 1890. She then complained of a copious, yellowish leucorrhœal discharge. Lately the discharge has assumed a thick and creamy appearance. Dysuria, difficulty in micturition, alternating diarrhœa with constipation, swollen abdomen, palpitation of the heart. The gastralgia has lately been very much improved by bromide of potash. Habitual sensation of constriction of the chest, weakness, anæmia. Various tonic preparations have been of no use. Anterior vaginal wall rather lax. Slight sinking of the uterus. Bimanual examination easy, because of the patient's emacia-

tion. Retroverted uterus, length almost 8 cm., softer than normal. Its mobility was diminished, but it was impossible for me to tell exactly within which limits. The left tube and ovary are agglutinated and form a small tumor, which is very sensitive to pressure, and only susceptible of a relatively small displacement. Several thin cords start from this tumor and continue in the direction of the sacro-iliac region.

The right broad ligament seems less elastic than normally, but it is only when I draw to the opposite side that I feel it to be the seat of small cords starting from the corresponding edge of the uterus and radiating outwards where they are not so easily palpable. Massage and stretching. They have to be performed very gently. On the fifth day the sensitiveness was somewhat increased, but there is no febrile movement. The treatment is interrupted. Absolute rest. Five days later it is resumed. No other complications. After a fortnight I am able to distinguish the tube and ovary from the rest of the morbid mass. At this moment the patient has to stop treatment because of urgent family affairs. I continued the treatment a month later. Four weeks after this the ovaries and tube have become quite free. They are no longer adhering to each other nor to the pelvic walls, there is a dilatation of the tube, as big as one's small finger, corresponding especially to its fimbriated extremity. The thin cords which I could feel before in the broad ligament on the right side are no longer perceptible to the touch. This one has regained its elasticity. The uterus has become movable. Her general state of health is very satisfactory. Three months after the end of the treatment I saw this patient. She had resumed her position as governess. At that time the uterus was less firm than at the last examination, 7.5 cm. long. The tube is no longer dilated. No more pain in the left side except after very long walks. The menses are less painful than in former years. The leucorrhœa is more serous in character and less in amount. At the last menstruation the blood seemed quite normal. Dysuria still present. Digestion excellent. No abdominal distension. Walks without any difficulty, no gastralgia. She has had gastralgia but twice since the treatment was begun, but the attacks were far less violent than before. The patient has gained strength and flesh. No complication of any nervous affection.

OBSERVATION LIX.

Perimetritis.—Adhesions to the Rectum.—Ovaritis; Interstitial Salpingitis.—Massage.—Improvement.

Mrs. C., 36 years of age, an ironer. Four pregnancies, the first one of which was terminated by an abortion; the rest went to full term, the last one 3 years ago. Eighteen months ago (July, 1885), violent mental emotion at the time of menstruation; chills, pain in the lower part of the abdomen, especially on the right side, even when standing. At the end of 3 months the pain quieted down, but did not disappear. The pain was constant and at times so severe that the patient was

obliged to stop in the street to catch her breath. From time to time, especially on having walked a good deal, she experienced a peculiar sensation as if she had a movable tumor on the right side. At the time of menstruation the pains were at times comparable to those at a confinement, being accompanied by a very painful sensation onf pressure in the rectum.

This patient, who was formerly robust and strong, has considerably emaciated. Her strength is less, she has frequent desires at micturition, sometimes 2 or 3 times an hour; the urine is something slightly turbid. No digestive disturbances, no constipation. Weakness was so marked that she had to give up her former occupation and become a dealer in ready-made linen. Two applications of the cautery relieved her a little while. Since then she has taken iron and quinine, without avail. An ulceration of the cervix was cauterized.

The uterus is slightly enlarged in size and retroverted, somewhat movable toward the front, but it assumes at once its former position. It is firmly attached to the rectum by adhesions, the latter very large, rather thick, and very sensitive. The left tube has the size of a lead pencil, but firmer and harder on pressure (interstitial salpingitis). The corresponding ovary is of the size of a pigeon's egg and very sensitive to the touch. The right ovary is slightly increased in size and painful.

Extension and massage through the rectum as well as through the abdominal walls was begun in December, 1886, at St. Louis Hospital. The condition of the abdominal walls is very favorable. The patient is, however, obliged to interrupt the treatment at the end of 3 weeks. Her condition is somewhat better, she insists that she is able to walk better. At the end of 5 weeks massage is resumed. The uterus can only partially be freed posteriorly; the right ovary is not sensitive, and has almost assumed its normal size. The left ovary is distinctly diminished in size, but still somewhat sensitive to the touch. The left tube is not so hard any more. The tuban walls are almost of normal thickness. There is still slight pain at the time of menstruation, but nothing in comparison to the pain that existed before. The sensation of pressure in the rectum has disappeared. Leucorrhœa has almost entirely disappeared; it is true, it was still somewhat present at the last menstrual epoch. The patient urinates from 5 to 6 times a day; the urine is much clearer. She has gone back to work.

Treatment was stopped toward the end of March, 1887. I heard from the patient in March, 1888. The improvement has kept up; leucorrhœa is very slight, and she experiences an almost insignificant pain at the time of menstruation.

OBSERVATION LX.

Perimetritis.—Salpingo-ovaritis.—Massage.—Almost Complete Cure.

Mrs. D., 30 years old, florist. Began to menstruate at 13, was regular, duration 3 days; chloro-anæmic, constant leucorrhœa. Married

at 20. Never pregnant. Six or seven months, profuse menorrhagia which lasted 3 days; immediately after this loss of blood, distended abdomen, with great pain on the left side. Almost constant dull pains on this side. Pains in the back. Habitual pain in the left side; on some days severer than on others. This pain is compared by the patient to a sort of intra-abdominal burning; it increases on walking, and radiates sometimes into the corresponding limb as far as the knee. From time to time pain in the back. Desires at urination frequent, urine cloudy. Habitual constipation, more marked since she is ill. Bowels move sluggishly, not without injections. Dysmenorrhœa. Palpitations and nausea.

April 10, 1891.—Length of uterus somewhat more than 7 cm.; its consistency diminished; virginal cervix. On the left side, a resisting tumor as large as a small walnut and flat; sensitive to the touch. It is impossible to make out in this tumor the ovary and the outer extremity of the tube. The greater part of the latter is free and slightly dilated. On the right side the ovary is large and hard to the touch, lying along the posterior wall of the uterus.

Treatment is well borne. After 3 or 4 weeks an improvement is noticeable; the patient walks better and feels stronger. The first menstrual period, which occurs 25 days after the beginning of treatment, is accompanied by slight dysmenorrhœa. The morbid mass disappears after more than 2 months' treatment; the latter is interrupted only during menstruation. The ovary and the fimbriated extremity of the left tube are completely separated; the tube is still dilated. The right ovary, which is also massaged, is less in size; it does not feel so hard any more. The uterus, in spite of all this, seems to be still a little larger than normally. This is massaged. Continuing this treatment for 3 or 4 weeks, the uterus gradually returns to its ordinary size; the left tube has, to a great extent, assumed its original size. The patient was presented at the clinic on June 8, 1891; all symptoms had disappeared; there only remained a slight dysmenorrhœa, which she can easily bear. I heard from this patient the latter part of October; her condition had remained the same.

CHAPTER XII.

Pelvic Adhesions—Special Manipulations Which They Require.

In the cases which we are about to report, as in those which have been referred to, the matter of retroflexion or retroversion, as well as of anteflexions (versions), which, as we have already mentioned, constitute quite a physiological condition, has been spoken of. As these malpositions, as well as the lateral ones, are frequently the result of adhesions and the retraction of the bands of inflammatory tissue, which adhesions are themselves the result of perimetritis or parametritis, it has seemed to me well to review how they influence the reproductive organs. It will then be easier to appreciate their importance from the standpoint of massage, and to determine what special deductions may be drawn from them, and what results can be expected from treatment.

I shall not speak of latero-flexions or latero-versions which do not cause any symptoms. I shall repeat, in the first place, what I have already mentioned in discussing massage of the uterus, that I do not believe that retroflexions or retroversions of themselves have any pathological significance. A congenital retroflexion may be present for years without the patient being aware of it.

These are sometimes found at autopsy, when they have never been suspected during life. The picture changes, however, when inflammatory symptoms arise. It is difficult to say why, in a woman with a retroversion or retroflexion, metritis or perimetritis should be more rebellious and painful than if the deviation did not exist. They are the cause of the inflammation, and tend to keep it up. If this complication is relieved the version may cause relapses. All that is necessary is not to consider how to relieve the inflammatory symptoms, but to remove their cause. The efforts of the physician ought to be directed to remedy the malposition and malformation. If you relieve this the rest will disappear. A large number of cases has been adduced to demonstrate this. I have not seen any cases of this kind, but this is no reason to deny the facts. The symptom-complex comprises two elements—one, flexion or version, the other the inflammatory symptoms. If one is suppressed the other will disappear. This does not say that either of these elements is of equal importance. This does not say that the malposition is the cause of everything. My own experience favors a contrary opinion. Many of my private patients whom I cured of metritis, para- or perimetritis, and where the uterus had become quite movable, as well as several treated at the St. Louis Hospital, in whom the treatment had been terminated 18-24 months previously, had their uterus in the same position after as when massage was first begun. In spite of this they have not had the slightest return of the symptoms.

I shall therefore continue to believe that retroversions

or retroflexions per se are of little importance; they can only give a peculiar clinical picture to the inflammatory symptoms. A point of importance in regard to the treatment is to use tact. If the patient thinks she is cured one must be careful not to disagree with her, even if a flexion or version is present. You may follow her for several months, and she will repeat that she no longer suffers; you are compelled to believe her. If, unfortunately, you or some other physician should happen to examine the patient and tell her that her uterus is out of place, you will surely have the patient return the next day and tell you that she is suffering and that her uterine displacement causes her permanent discomfort. She will not stop suffering until she has been persuaded that her uterus is in a normal position. What I have said applies equally to ante-, postero- and latero flexions and versions.

We have spoken of disturbances of the venous circulation following changes in direction, and of the action of the increased weight of the uterus due to the increased venous congestion. This is a theoretical explanation of the symptoms observed. This is worth no more than other hypotheses. I do not regard torsion of the uterus and the broad ligaments as having the importance attributed by certain gynecologists, when numerous and definite facts do not support this view. What I have just said applies equally to deviations due to traction of pelvic adhesions as well as those which are freely movable.

All adhesions do not produce such characteristic results as those which fasten the uterus to neighboring organs. There are some adhesions between the ovary

(tube) and intestines, for example, which are so loose as not to produce any symptoms. These are sometimes torn by the slightest pressure of the finger when the pelvic organs are carefully examined; in most cases this tearing of the adhesions produces no bad results.

But the physician need not concern himself with trifling lesions which produce hardly any discomfort to the patients. What interests him are firm, cordlike and membranous adhesions. Some physicians break up these adhesions under an anesthetic. This procedure appears to me so bold that I hardly dared to imitate it, and I do not advise anybody to follow it. The forcible stretching of adhesions, recommended by Schultze several years ago, under chloroform narcosis, appeared to me to often expose, if not always, to lacerations of which I am afraid. You may proceed as Schultze, at a single séance[1]; as Gottschalk[2], in two séances, with an interval of 24 hours; in two séances within a week, as Ter Gregoriantz[3]; it is all the same. It is always equally dangerous. No matter how accurate the diagnosis or how delicate the touch, it is impossible to perform the manipulations with such precision as to be sure that the desired end has been attained. I like to proceed slowly and with method, the patient fully conscious, because her sensibility is always an infallible guide. It is always necessary to know how far you may go in a woman, and to be guided by

---

[1]Pathologie und Therapie der Lageveränderungen der Gebärmutter; Berlin, 1881.

[2]Centralblatt f. Gynäkol; 1889, No. 8.

[3]Centralblatt f. Gynäkol; 1888, No. 13.

the facial expression, if the patient is sufficiently courageous to tolerate the manipulations without complaint. In this way you have a useful indication when to stop, if you want to avoid forcible stretching and often deep laceration. Prochownik mentions that he has met with attacks of acute perimetritis in patients whom he had thus treated. He thinks these attacks were due to laceration of adhesions. These lacerations certainly could not have been produced had the patients been conscious. Fortunately, these symptoms were soon relieved and did not give rise to any untoward complications. On general principles, it is not considered advisable to forcibly stretch adhesions while the patient is entirely unconscious. The great danger of causing lacerations in a closed cavity filled with a large amount of cellular tissue and delicate organs, such as the organs of generation and the intestinal coils, enveloped by a delicate serous membrane which reacts quickly to any irritation—these ought to be sufficient to cause the rejection of this procedure. If Schultze and many others did employ this procedure in spite of this, it was because they exaggerated the importance of uterine deviations. Convinced that they could restore the uterus to its normal position, before thinking of any other method they forcibly stretched the bands and adhesions, which they lengthened suddenly or tore. They did not, however, call this forcible stretching or tearing. To repeat, I consider this manner of interference dangerous and am afraid to employ it. It appears to me that a procedure ought to be employed which

attains the desired end and does not expose the patient to any risk. It is surprising to observe how even those uteri which cannot be freed under anesthesia are gradually loosened under massage. Thus Brandt loosened a uterus with massage which Schultze had failed to loosen, after repeated efforts, under anesthesia. Ziegenspeck believes that after long continued massage and repeated efforts the adhesions become softened and succulent.

I have discussed at great length concerning petrissage in parametritis. A connecting band can scarcely be kneaded; it must be stretched. Brandt has given some excellent rules regarding this, which I have always followed to the letter. Thanks to his vast experience and his keen observation, he had arrived at a technic which was almost perfect. Stretching must not be undertaken until complete organization of the exudate has taken place; that is to say, after the absorption of the liquid elements. Then the danger of setting up an acute attack need not be feared. The adhesions are gradually stretched by the tip of the index finger, without attempting too much at each séance. By stretching we do not mean tearing. When you obtain some result, no matter how slight, you must be satisfied. In this way you gradually obtain the end desired without subjecting the patient to any danger. This manipulation is repeated several times at each séance. It causes slight local irritation, due to the pressure made with the external hand and below the adhesion. Sometimes this irritation gives rise to distinct swelling, very sensitive to the touch, or also—this is rare—to a real tumor, which, however, was

never followed by any untoward complication. This is only œdema, which can be quickly diffused by effleurage in two or three séances.

It goes without saying that the rapidity of the results depends on the duration and tenacity of the adhesions. If these are soft and distensible only a few séances are necessary. Very firm and hard adhesions and bands require much perseverance. It is better not to begin the treatment unless you have sufficient patience to wait for the desired results. You cannot predict how long it will take to stretch the adhesions; experience is the only guide. I have often met with such hard and strong adhesive bands, which so firmly fixed the uterus, that I asked myself whether it was worth while to try to distend them. After numerous séances I am content if I can stretch the adhesions sufficient to obtain a partial rectification of the position of the uterus and considerable mobility.[1] I have attained this without attempting, if possible, to avail myself of the softening of the adhesions which occurs at the menstrual epoch, as Brandt has done.

The adhesions must not be stretched with too much force, nor too long, for local irritation may be set up which renders the procedure useless. On the other hand, the manipulation must be sufficient, and the index finger must touch and stretch the band, otherwise no results

[1]The bands yield and stretch, but are rarely absorbed. I have at times obtained so much yielding that an uterus previously fixed in retroversion by adhesions in Douglas's cul-de-sac could be brought into its normal position, or even into a position of slight anteversion, at least for a time.

are obtained. The direction of the pressure must, in most cases, be vertical in relation to the walls of the pelvis. It is self-evident that an extensive adhesion must not be attacked in its entirety at one séance. I begin at one point and, after having obtained some elongation, I pass to another portion. This applies to all adhesions, even to those of the tubes and ovaries, which I shall discuss later on.

I treat my patients while they are conscious and am very seldom surprised by some accident. The sensitiveness of the patient is not the only guide, the muscular sense of the physician is equally important in determining the amount of force to be employed. In a beginner this sense is not as well developed as it will be later on. At first the tactile sense does not appreciate the point beyond which one may not go, without tearing the adhesions. This touch later on becomes almost instinctive. The possible complications are rare and insignificant. They are slight local irritation of transitory nature and, in the severest cases, slight attacks of extremely circumscribed pelvic peritonitis, which are treated by the usual remedies, and chiefly by discontinuing the massage a short time. This requires but a few days. By effleurage and very gentle frictions, swellings as large as an egg may be caused to disappear in from two to three days.

Adhesions of the fundus of the uterus and of the pubic symphysis require special mention. These are uncommon, and are the result of a precervical perimetritis. They are ordinarily firm and hard, and immo-

bilize the uterus in anteflexion. They can hardly be effectually influenced except with the thumb introduced into the vagina, the nail toward the symphysis and pressing strongly with its tip. If the case is a difficult one, it is better to place the patient in a vertical position. The physician sits in front of her, his left elbow resting on his left thigh. He exerts a gentle, continuous pressure, but strong enough, however, to stretch the adhesion, by elevating his leg.[1] Thus repeated stretchings for some time will soon give sufficient mobility to the uterus to permit the fingers of the other hand to be placed between the uterus and pubic symphysis and meet the thumb through the abdominal wall.[2]

At this moment you cause the patient to lie down and the pressure is continued with both hands. It is well, if possible, to grasp the uterus with the external hand and cautiously apply gentle pressure upon it from behind. In order to facilitate these to and fro motions it is well to push the cervix forward with the two fingers in the anterior cul-de-sac. These manipulations are forcible, but the adhesions against which they are directed are sometimes so firm that it takes two months and longer before the uterus regains its mobility.

Lateral deviations are very frequent. Their treatment by massage and stretching of the adhesions must be regarded as favorable when the uterus can, without

---

[1]You thus gain power, are not so easily tired out and can better control the force employed.

[2]Even in normal conditions the thumb can easily be felt by the external hand, because they are only separated by the abdominal wall, the anterior vaginal wall and bladder.

pain and much resistance, be pushed away from the point of fixation.[1] It is more difficult to do this in posterior deviations, which are due to retraction of adhesions, which are at times hard and firm, and again cicatricial and cordlike. In these latter cases you cannot hope for disappearance of the adhesions even after prolonged treatment, although they may be much diminished in size, and at the same time—and this is perhaps more important—they become more distensible. If the bands of adhesion are especially thick and hard it is useless to attempt to stretch them at once. In such cases it is better to massage for a time, until the adhesions become somewhat elastic; then you can resort to stretching, especially a few days before or even during menstruation, if necessary. When the adhesions and periuterine tissues have become softened on account of the congestion, they are rendered succulent, supple and distensible. At this time they are more apt to yield to massage, and can be stretched in the oblique diameter of the pelvis, if the adhesions are, as is most frequently the case, situated on one side. The conditions are still less favorable if the adhesions are bi-lateral, because they are situated lower down in the pelvic cavity and difficult to reach through the abdominal wall. It requires considerable skill and experience to know when and how

[1]You introduce one or two fingers into the rectum or vagina, behind the inflammatory exudate, while the other hand manipulates, if possible, through the abdominal wall. It is necessary, at the same time, to make use of the uterus as a sort of lever, and the external hand grasps it as high as possible and pushes it in a direction opposite to where the adhesion is.

to attack them. The patient must have confidence in the method and persevere. I have treated a number of patients affected in this way and seldom have met with any severe disappointment. Three months are sometimes necessary to obtain any good results, and the manœuvres are painful and fatiguing. Frequently only some loosening is obtained. If the fundus of the uterus can be raised to the level of the promontory or further, much has already been accomplished.[1] The result obtained, however incomplete, is not to be despised, and when this has been accomplished I feel well satisfied, because the symptoms of which the patients have previously complained are relieved; all the more, since these cases would have required surgical intervention and necessitated the breaking up of the adhesions and often laceration of the parts. Adhesions which fix the uterus to the posterior pelvic wall are not always caused by previous exudates in that portion of the pelvis. I believe they are just as frequently secondary and due to friction between the parietal and visceral peritoneum, which causes an inflammatory condition, with fibrino-plastic exudate. This in turn becomes organized and forms the adhesion.

When these adhesions are thin, the conditions are favorable; when, however, they are thick, almost insurmountable obstacles present themselves. I shall now describe how I proceed in the former cases. The patient lies in a recumbent position. The right index finger is introduced into the rectum, as far as possible through the

[1]It is well at this moment to carry the uterus directly forward, in order to stretch the adhesions on both sides.

restriction, and the fibrous adhesions are stretched. With the same finger the uterus is repeatedly pushed forward, the finger pressing each time at a different point. When the adhesions are sufficiently stretched so that the uterus can be markedly reduced I grasp it with the hand and continue to use it as a sort of lever to complete the stretching.

In slight cases I frequently succeed in freeing the uterus in two or three weeks. Occasionally I have cases where the results are not so good, and where the adhesions only yield after long and persistent application.[1] Even a partial result suffices to relieve the symptoms.

Good results are rarely obtained where there are large adhesions to the rectum; it is not difficult to bring the uterus forward, but owing to the contraction of the muscular fibres of the rectum and its elasticity, the uterus quickly resumes its formal malposition. In similar cases I have followed the procedure advised by Brandt, as follows: The hand grasps the fundus through the abdominal wall and is pushed down between the uterus and the posterior wall of the pelvis until stopped by the adhesion of the uterus to the rectum. Two fingers inserted into the vagina[1] hold the cervix and press it upward and forward.[2] Then light friction is performed through the abdominal wall with the tip of the fingers, closely following the posterior uterine wall, so as to press

[1]The patient may assume the knee-elbow position, and the uterus may be pushed forward and downward with the index finger. In order to facilitate this manœuvre you press the cervix upward and forward.

[2]The two fingers in the vagina are crossed so that they hold the cervix just as a pessary.

the uterus away from the rectum in a forward direction. All violation must be avoided. This manipulation is fatiguing, and slight rest is required from time to time. Rarely the adhesion can be completely loosened. In most cases partial freeing only is obtained, and still the symptoms are fortunately ameliorated.

CHAPTER XIII.

Discussion of Chronic Affections of the Uterus With Their Complications.—Chronic Metritis.—Ulcerations of the Cervix and Catarrh of the Uterus.—Results of Massage.

If, in a book devoted to massage of the uterus, the above affections are omitted, it might be concluded that there is an absolute independence of the uterus, its neighboring organs and its adnexa, and that there is no connection between them from a pathological as well as therapeutic point of view. We have never held this opinion, and we do not wish to be understood as holding it now. On the contrary, it is rather rare for the uterus to be unaffected in cases of chronic para- or perimetritis. There are nearly always troubles resulting from the chronic venous stasis, which is the invariable result when there is a large and firm exudate in the broad ligaments, when there is fibrous tissue compressing veins of a certain calibre. The swelling and chronic engorgement of the uterus result from this. These are complications which disappear under massage and stretching as soon as normal conditions have been re-established and the compression relieved. The cure of the peri- or parametritis is generally followed by relief of the conditions which are caused by the passive congestion of the uterus. If, however, this congestive state has produced

an increased density of the organ, it is difficult to obtain relief without massaging also the uterus, which is likewise necessary where metritis (endometritis) constitutes the primary disease, and where the inflammation of the adnexa is but a complication.

Ulcerations[1] constitute a frequent symptom of chronic metritis as well as indirectly of para- and perimetritis, and unnecessarily alarm the patients as well as physicians. In general these ulcerations are very rebellious to treatment, and seem to persist in spite of powerful caustics, which at the most, can have but a temporary and palliative effect. The ulceration, however, disappears as if by magic at the moment it assumes the character of an isolated affection and the parametritic exudate, adhesions and metritis have disappeared. It has always appeared to me that this cohdition was a disturbance of nutrition due to the uterine venous stasis, sometimes kept up by irritating discharges from the uterus and vagina. The rule is, the greater the passive congestion, the worse are the ulcerations. If the symptoms have existed a long while and the ulcerations are exceptionally large and deep, I have seen them persist even after the course of massage had been finished, but their appearance was so changed that they looked as if they were not far from complete cure.

---

[1] I speak here only of the real ulcerations and not of the more superficial ones, which are due, it seems, to the contact of the irritating liquids, secreted by the uterus and particularly the vagina, and which only consist in a desquamation of the pavement epithelium of the vaginal mucous membrane of the neck of the uterus—easily curable as soon as the irritating secretion has ceased.

My predictions were almost never wrong; when upon my recommendations the patients returned in a month or two the ulcerations were mostly healed, although they had not pursued any further treatment. Superficial cauterization may be resorted to in rebellious cases, in order to hasten the healing, but it must then be done, of course, toward the end of the course of treatment by massage. Still, this medicinal adjuvant is undertaken in the majority of cases merely to satisfy the patients. If these patients have been told by a physician that they have ulcerations, as is frequently the case, at first they do not speak much about them, because the pain, leucorrhœa and metrorrhagia do not give them any chance to think of them; later on, however, when these symptoms have disappeared, their thoughts are again directed to the ulcerations. It is difficult to convince them that they are not serious and will get well of themselves. They rarely begin a séance of treatment without asking about this affection; they cannot conceal their anxiety. These ulcerations always have a tendency to recur at times after they have been healed by some local treatment, in this respect resembling varicose ulcers. There is no reason for alarm on account of this. When the venous stasis has been relieved by massage there is little fear of recurrence.

Uterine Catarrh is another common complication. It is most frequently secondary, and on this account local applications have been thus far so unsuccessful. Astringent injections, counter-irritants and caustics no longer suffice; neither does curettage. Moreover, in case of

inflammation in the adnexa this operation is contraindicated, as it may cause an acute attack. It hardly ever gives good results in this condition. There may be temporary improvement, but all the symptoms will recur, because the origin of the process is not in the mucous membrane.

CHAPTER XIV.

Diseases of the Tubes and Ovaries. — Its Application in Diseases of These Organs.

Forty years ago *inflammation of the tubes* was hardly mentioned. Too little attention has been given to this subject, as it is quite natural to suppose that when these are seriously involved as a result of uterine or ovarian affections they change the clinical aspect of the case and may furnish indications for treatment. Nowadays perhaps too much stress is laid upon the tubes. It is almost believed that their primary and localized affections dominate the pathology of the entire female genital apparatus. This view is radically wrong, as nothing is rarer than a primary uncomplicated salpingitis, than a lesion wholly confined to the tube. Nine times out of ten the starting point is a metritis which has gradually progressed toward the orifice and mucous membrane of the tube. Later on there is a sort of inversion of the terms, and the uterus, which was at first the cause, plays a secondary part and its place taken by the tube. After treatment and improvement of the metritis the salpingitis persists. These secondary invasions are almost exclusively confined to the mucous membrane. According to the latest researches, blenorrhagia seems to play an important part, although perhaps exaggerated, as it has a tendency to fix itself in the racemose glands of the cervix and

remain there a long while before going higher up into the uterine cavity and invading the tube. Whenever the question of treatment of periuterine affections by massage arises, the condition of the tubes and ovaries must be carefully considered. This is not always easy. The normal tube is difficult to find on account of its small size and great mobility. It constantly eludes the examining finger, but when swollen and œdematous, as is the case with all pelvic organs a few days before and during menstruation, it is more readily felt. In diseased conditions the larger and thicker it becomes the greater is its tendency to fall into the Douglas cul-de-sac, where it is perhaps more frequently found than the ovary, which it will often, under such circumstances, drag along. Furthermore, there is hardly a single organ in the pelvis to which the tubes may not be united by adhesions; and they may be adherent to the lateral walls of the pelvis or the abdomen.

It has generally been advised that to feel the tube the finger must be pushed to side of the cornu of the uterus. This is perhaps not so easy, as it may be mistaken not only for the round, but also the ovarian ligament, which arises here.

Sometimes you find on one side of the pelvic cavity a large mass whose precise nature it is difficult to make out. The treatment is a diagnostic point; when the absorption of the exudate takes place the various parts which were at first united in a single mass become free and distinct, and it is often possible to distinguish the tube, ovary and intestinal coils. In combining petrissage,

with the tension cautiously applied, as I have above explained, the desired results are obtained and the organs frequently regain their former mobility. What, then, is necessary if the tube can be felt and is diseased? Brandt believes that massage might be attempted even in cases of salpingitis with a tube containing liquid, as a result of occlusion of the ostium abdominale. He makes gentle frictions from without inward; that is to say, from the abdominal toward the uterine orifice, in order to hasten the discharge of the serous, or sero-sanguineous fluid, which is sometimes observed to take place spontaneously, even intermittently, into the uterine cavity. Thus far I have not applied this procedure, because I was afraid of the possibility of doing harm. It is difficult to determine what a dilated tube contains. Frequently surgeons who operate, thinking they have to deal with a small or medium sized hydrosalpinx, find to their surprise that they have a pyosalpinx to deal with, and, on the contrary, a hydrosalpinx is found where a pyosalpinx is suspected. It is equally difficult to say that the discharge will take place directly from the tube into the uterus and that not a drop enters the abdomen, in case the ost. abd. is not entirely closed by previous local perimetritis or that a real rupture of the sac will happen. The peritoneum, little tolerant to liquids of any kind, reacts in a peculiarly unfavorable manner when pus enters its cavity. Brandt did not recommend this manipulation with the same conviction as many others. If he did not obtain quick results he ceased massage. I have thus far believed that it would be better not to undertake this than to risk too much for such an uncertain result.

I am less positive in cases of chronic salpingitis accompanied only by slight dilatation of the tubes. If they contain fluid, it is in small quantities; and the tension of the tube is consequently not so great. Massage is then not so objectionable and gives good results. I have also frequently seen such cases of salpingitis disappear without direct intervention as soon as the uterine catarrh was relieved.

It is in these words that I expressed my opinion ten years ago in my French work, "La Massage dans les affections du voisinage de l'utérus et de ses adnexes."

In the last few years I am less positive than I formerly was, and I have modified my views on the subject in question since. I have learned the researches of Prochownik, which have clearly shown that in three months after infection the germs are no longer virulent. These investigations ought to be absolute proof of the impunity of conservative intervention in those cases of pyosalpinx which are not of too recent a date. Moreover, what I have learned has been confirmed by many gynecologists who practise massage, Ziegenspeck among others, and who have not had any serious consequences, on account of a rupture of the purulent sac, which is worth remembering. Moreover, Prof. Curschmann, of Leipsic, has lately demonstrated that a great and persistent increase of leucocytes in the blood is produced by an abscess. These observations have just been confirmed by Dr. Dutzmann[1], in the gynecological clinic of Greifswald, particularly in reference to tubal affections, and to

[1]Centralbl. f. Gynekologie, 5 April, 1892.

such a degre that in many cases before operative interference, the probable diagnosis derived from the clinical symptoms, was contradicted by the increased leucocytosis.

In view of these results, if they are confirmed, massage of the tubes may be employed without running the risk of their rupture.

In one case reported the tube was the size of an index finger, full of liquid, and was adherent to the abdominal wall. No symptom could apparently be attributed to this peculiarity. In *interstitial* salpingitis, with thickening and hardening of its walls, massage acts well, at least in reducing its size.

Tubal adhesions must not be roughly handled; too many precautions cannot be taken in detaching or stretching them, if you do not wish to run the risk of rupturing the tube and its possible complications, since the tube is in these cases distended with a fluid almost always purulent in character. In order to avoid rupturing the tube it is necessary to introduce the fingers far into the rectum, behind the tube, carefully avoiding any pressure and endeavoring to reach the adhesions. When the adhesion has been reached, it is steadied with the finger and then slight traction is made through the abdominal wall. It is also possible to do this by fixing the hand on the abdominal wall and making the traction with the finger in the rectum. Then the adhesion is massaged at the same séance, which is concluded by gentle and superficial manipulations, which allay the irritation produced by the traction. It is necessary to keep as much as possible away from the tube, in order that the manipula-

tions of massage and the traction be exclusively confined to the adhesions and thus avoid working on the peritoneum proper, close by.

In a great many cases the results obtained by this procedure are not very satisfactory, on account of the difficulty of reaching the adhesion, which frequently is very tender to the touch, and principally on account of the impossibility, not to say danger, of making use of the tube as a lever. When the tube, on the contrary, is adherent to the lateral pelvic wall or to the hollow of the sacrum (which is very rare) the results are more favorable.

Ovaritis.

The ovary is a very movable organ, almost as freely movable as the tube, and eludes the examining finger, making it more or less difficult to feel it. It is rather exceptional to find it in its normal position. Even in cases which are not exactly abnormal, especially in multiparæ, the suspensory ligaments, and particularly those which attach the ovary to the pelvic wall, allow the ovary to descend on account of its own weight and occupy the position in which it is very often found, on one side of the uterus, near its lateral border. It can be most easily felt through the abdomino-rectal route, provided the examining finger can reach high enough above the third sphincter. In this way you can explore the entire posterior uterine surface, Douglas's pouch, the parametrium on both sides, as well as the fundus of the uterus, and in favorable cases reach even high enough in the pelvis to explore its highest portions. Massage

rarely, except in recent cases, gives what might be called recovery, that is to say, *restitutio ad integrum*. In chronic cases, when the pain diminishes or disappears, we must be satisfied. Sometimes the ovary is painful and œdematous, which facilitates its examination. Massage employed under these circumstances causes the œdema to disappear at the same time as the pain in a very short time—sometimes in a few days.

What is most surprising and for which you cannot account, is how it acts. Even though the ovary always diminishes in size under the influence of massage, it rarely resumes its normal size. When the ovary is indurated it frequently becomes softer; the tenderness, which is due to the periovaritis, is relieved, even completely disappearing. Periovaritis may exist alone, or almost alone, and be unaccompanied by any inflammation of importance of the underlying ovarian parenchyma. This is more frequent, I think, than is generally believed. If this is the case the condition is soon relieved and requires very gentle manipulations, in order not to aggravate the condition.

The treatment of ovaritis requires two months, or even more, if there are adhesions, which are loosened in the same manner as those of the tube. It is very difficult when the ovary is fixed very high in the pelvis, in the neighborhood of the sacral promontory. Even after prolonged efforts only slight, if any, stretching of the adhesion is obtained. The stretching of the adhesions becomes more difficult when the ovary lies in Douglas's cul-de-sac and is bound down by adhesions. The con-

ditions are then very unfavorable, especially when the adhesions are dense, and by retraction favor displacement. Under these circumstances you cannot often hope for good results.

Adhesions to the uterus are relatively easy to detach.[1]

In the cases which precede I have mentioned salpingitis as a complication of ovaritis, i. e., periovaritis. I report here a case (No. LXI) of chronic ovaritis, complicated by interstitial salpingitis, as well as chronic parametritis; also a very interesting case of *chronic periovaritis* (No. LXII), treated in this country.

OBSERVATION LXI.

Oophoritis Sin.—Salpingitis Interstitialis Sin.—Parametritis Sin.—Massage.—Relief of the Symptoms.

Mrs. L., 25 years of age. Ten months ago, a profuse sero-sanguineous discharge, as a result of fatigue, before menstruation. For some days preceding this she experienced a sensation of heaviness in the lower part of the abdomen, accompanied by hypogastric pain, a sort of gnawing sensation. These symptoms diminished in the same degree as the menstrual flow was being established; the attack ceased gradually. Four months later, in the beginning of 1889, a few days after menstruation had stopped, a similar discharge came on, without being accompanied either by pain or by heaviness. The amount of fluid lost was much less than before; at the end of a few days, leucorrhœa abundant, yellowish-green, thick; then the fluid assumed the character of the white of an egg.

Since a few weeks the patient experiences violent pains in the hypogastric region, with irritation in the bladder and frequent desires at micturition. Walking is difficult, as it brings on the pain or increases it so as to render it almost unbearable. The uterus is a little larger than normally, but in its normal position; it is movable in every direction. The inferior border of the left broad ligament is thickened, rigid, very sensitive to the touch. The ovary of the corresponding side is also increased in size and painful to the touch; the tube likewise, but the increase in size is confined to the parietal portion.

---

[1] Adhesions to the anterior abdominal wall are likewise very difficult to reach. This is probably due, as Brandt has mentioned, to the impossibility of reaching them from behind.

Very slight leucorrhœa, especially before and after menstruation. The patient is very much emaciated, which facilitates massage. I commenced it on November 4, 1890. During the first week the patient complains when I touch the ovary and the left tube; she complains of a sharp pain on this and even on the right side. After 4 séances walking becomes easier. At the end of 6 weeks massage is stopped because the patient declares herself completely cured. The left ovary not far from normal size, no unusual pain on pressure, as on the right side; the size of the tube has diminished, its resistance is still somewhat increased. The broad ligament on the same side of normal elasticity. The patient is able to walk without any trouble. Three weeks ago she started in to work again as laundress. She was presented at the clinic on December 21, 1890; again on December 4, 1891. She had remained entirely well.

OBSERVATION LXII.

Periovaritis.—Dysmenorrhœa.—Cure.

Mrs. C., 40 years old, from Albany; of a rather delicate constitution; began to menstruate at 16. No dysmenorrhœa at this time; the sanguineous flow is, however, a little abundant. Married at 20; abortion, followed by peritonitis, at third month. Menstruation now accompanied by pains in the lumbar and ovarian regions; these pains have constantly increased. Since several years they have become so violent that at each period the patient is obliged to stay in bed for 48 hours, and she does not get any relief until the first few drops of blood have appeared. Besides, she experiences a very painful sensation in the hypogastric region, bearing down pain, pains in the back; there is an almost constant pain and pressure toward the rectum, especially severe at the time of her periods. Ever since the patient has been taken sick, and every time the menstrual periods appear, they are preceded for 4 or 5 days by a sensation of fulness in the right breast, which increases in the same proportion as menstruation approaches its maximum; on the day that menstruation appears she experiences the most painful pressure. As soon as menstruation is established the breast begins to get smaller, and at the end of 48 hours it is again normal.

Digestion poor, very often accompanied by colicky pains; constipation; frequent desires at micturition. Always obliged to wear an abdominal bandage. Cauterization of the cervix; warm baths; also injections containing laudanum at the time of appearance of menstrual dysmenorrhœa; curetted thrice, with relief of local symptoms, but, unfortunately, of only short duration. Six or eight weeks later she was in the same condition again.

I saw this patient for the first time in January, 1900. The uterus somewhat enlarged, in marked anteflexion; of slight consistency, sensitive to pressure and completely movable. The cervix is the seat of a superficial ulceration in its posterior lip extending into the cervical canal. Both ovaries, especially the left one, are very sensitive to the

touch (Periovaritis), but not increased in size to any marked degree. Neuralgia in the right ilio-inguinal region. Not the slightest relief at the time of menstruation which followed the beginning of treatment. At the time of a séance which corresponded to her second menstrual period, and which was 48 hours behind time, as she was still free from pain, the patient said while lying down on the bench to submit to the treatment: "I don't understand why I don't get unwell." Great was my surprise when I withdrew my two fingers and found them covered with blood.

After 51 days of very gentle massage of the ovaries, the patient's condition was as follows: The pains in the back, as well as the bearing down pain, have almost disappeared; frequent desires at micturition exist no longer; digestion good; constipation relieved; on the whole, the patient feels remarkably well. She has gained strength and flesh in a marked degree. The patient is greatly pleased with the result obtained, and she returns to Albany, to come back to see me 10 months later. Improvement has progressed. She has no more dysmenorrhœa. The pains were so slight that when she travelled from Albany and return, this time to New York, she felt almost no pain, whereas thrice before, when she made the same journey in order to seek relief in the latter town, she was seized by one of those almost unbearable pains in both sides as well as in the back. Her breast shows no tendency to enlargement at the time of menstruation.

In conclusion I must make mention of one other application of massage, namely, after *hysterectomy*, especially vaginal, in order to hasten the resolution of post-operative disorders, which sometimes exist even in the most favorable cases, and which annoy a great many patients, who believe that after the operation they ought to be free from all symptoms. Massage in these cases is very rational and frequently yields excellent results as an adjunct to the operation.

BIBLIOGRAPHY.

BUNGE. Beiträge zur Massage des Unterleibs. Berliner Klin. Wochenschrift, 1882, No. 25.

FRAENKEL, E. Breslauer Allg. Zeitschrift, 1888, No. 10.

PROFANTER. Massage in der Gynäkologie, Wien., 1887.

ROSENSTEIN, Centralbl. f. Gynäcologie, 1881.

SEIFFART. Die Massage in der Gynäcologie, Stuttgart, 1888.

WINAWER. Centralbl. f. Gynäcologie, 1888.

WEISENBERG. Centralbl. f. Gynäcologie, 1889.

BRAUN, v., und KREISEL. Klinische Beiträge zur manuellen Behandlung der Frauenkrankheiten, Wien., 1889.

1890-1891.

JENTZER und BOURCART. Gymnastique Gynecologique, Geneva, 1890.

PROCHOWNIK. Die Massage in der Frauenheilkunde. Hamburg und Leipzig, 1890.

SAENGER. Ueber Zugmassage, Centralbl. f. Gynäcologie 1890.

HALBAU. Monatschr. f. Geburtshülfe und Gynäcologie, 1890.

DÖDERLEIN. Centralbl. f. Gynäcologie, 1890, p. 125.

FREUDENBERG. Ueber mechan. Behandlung von Gebärmuttergeschwülsten, Berlin, 1890.

DUEHRSSEN. Ueber den Werth der Gynäcologischen Massage nach Thure-Brandt, Berlin. Klin. Wochenschrift, 1891, No. 44.

LEOPOLD. Centralbl. f. Gynäcologie, 1890, p. 116.

KUMPF. Centralbl. f. Gynäcologie, 1891, No. 25.

CEVELIA. Internat. Klinische Rundschau, 1890.

KUMPF. Verhandl. der Deutschen Gesellsch. f. Gynäcologie.

ZWEIFEL. Centralbl. f. Gynäcologie, 1890.

GOTTSCHALK. Berl. Klin. Wochenschrift, 1891.

TAYLOR. New Med. Journal, 1891.

1892.

STACKER. Centralbl. f. Gynäcologie, 1892.

LOMER. Centralbl. f. Gynäcologie, 1892.

ASHKENAZY. Kinesitherapie und Massage. Lemberg, 1892.

KUMPF. Ueber manuelle Behandlung der fixirten Retrodeviationen des Uterus nach Thure-Brandt. Verhandl. der Deutsch. Gesellsch. für Gynäcol., IV. Kongr., p. 402.

LEBLOND, E. Affections uterines traitées par le massage. Actualité Med. Paris, 1892, pp. 129, 147.

NISSEN, O. Erfaringer om den Thure-Brant'sche Uteringymnastik; Forhandl. ved de Skandinav. Naturforskeres 14. Mide, p. 615.

NORSTRÖM, G. Massage dans les affections du voisinage de l'uterus et des annexes. Paris, 1892.

RIES, E. Ueber die Bedeutung und den Werth der Gymnastik in Verbindung mit der Brandt'schen Massage. Deutsche Mediz. Wochenschr., 1892, p. 402.

STAPFER, H. La kinésithérapie gynécologique; traitement suédois des maladies des femmes (méthode de Thure-Brandt). Ann. et de Gyn. et d'Obst., Paris, 1892, Tome 38.

ZIEGENSPECK und O. SCHMIDT. Einige bemerkenswerthe Fälle von Heilungen durch Thure-Brandt's Massage. Aerztliche Rundschau, München, 1892, p. 469.

1893.

BRANDT. Traitement des maladies des femmes.

BUMM. Centralbl. f. Gynäcologie, No. 42.

COOPER, C. E. The Brandt method of treating pelvic disorders in women. Occident. Med. Times, pp. 307-310.

EUMENIEFF. Ueber die Bedeutung der gynäcol. Massage in der Landschaftspraxis. V. Kongress russischer Aerzte zum Andenken von Pirogroff.

OTTI. Allgemeine Wien. Med. Zeitung.

VINEBERG, A. N. Two years' experience with pelvic massage in gynec. affections. Med. Jour., New York.

WALTER, J. Pelvic massage. Am. J. of Obst., New York, 1893, pp. 876-889.

SAENGERS. Landauer Mekanotherap., 1893.

1894.

GOLDSPIEGEL, S. Traitement des maladies des femmes par la méthode de Thure-Brandt. Arch. gén. de Med., Dec., 1894.

HARDY, G. Quelques observations de massage en gynécologie. Ann. Soc. Méd., Chir. de Liége, pp. 111-116.

HERTZCH. Zur Massage nach Thure-Brandt. Monatschrift für Geburtsh. und Gyn., Bd. I., p. 252.

HOGNER, R. On the value of kinesitherapy in gynecological practice. Journ. of Am. Med. Assoc., p. 115-119.

LEDER, CECILE. Un cas de stérilité guéri par le massage. Arch. de Tocol. et de Gyn., Vol. XXI., p. 276.

MARCHAL, B. Local massage in the treatment of certain gynecological conditions. Glasgow Med. Journ., p. 203.

MOTTE. Massage et hydrothérapie dans les affections uterines. Bruxelles, 1895.

PETERS, A. Beitrag zur Statistik der Erfolge der Massage-Behandlung bei chronischen Krankheiten der weiblichen Beckenorgane nach Thure-Brandt. Inaug. Diss., Kiel.

PONOMAREFF. Ueber die Anwendung der Massage in Frauenkrankheiten. Notizen der Ural'schen Med. Gesellsch. zu Yekaterinenburg, IV. Jahrg., p. 38.

RUBINSTEIN. Zur polyklinischen Behandlung der Frauenkrankheiten mit Massage, Eshenedelnick, No. 12, p. 44-46.

RUMPF, W. H. Pelvic massage in gynecology. Am. Journ. of Obst., Vol. XXXI., p. 37.

TENESVARG. Thure-Brandt. Orvosi Hetilap No. 41.

SCHULZ. Klinische Beiträge zur Th. Brandt's Behandlung.

MAYER, O. J. Massage in gynecology. Jour. Am. Med. Assn., Chicago, pp. 236-240.

OTT. Ein Beitrag zur Thure-Brandt'schen Methode der Massage in der Gynäcologie. Allg. Wiener Med. Zeitschr., 1893, pp. 565, 580.

POLUCCO, R. Il massagio nella cura delle malattie giecologiche. Annali di Ost. and Gin. Jennaio.

STAPFER. La gymnastique gynécologique. L'union méd., p. 689.

STRATZ, C. H. Gynaikologische Massage. Med. Weekbl. v. Noord u. Zuid, Nederland, Jahrgang, No. 8.

TIMMLING, K. Ueber Massage, insbesondere Dehnung und

Lösung der abnormen Fixationen des Uterus und seiner Adnexa, Berlin, 1894, p. 33.

Wallin, M. The treatment of skoliosis and the Brandt method of pelvic massage. Med. and Surg. Reporter, Vol. LXX.

Heitzmann. Centralbl. für gesammte Medicin, 1894.

1895.

Dolega, M. Heilgymnastik bei Frauenkrankheiten und Massage bei Krankheiten des Uterus und seiner Umgebung (Methode Thure-Brandt). Nach dem Französichen von Fentzer und Bourcart. Inaug. Diss., Leipzig.

1896.

Leder, C. 18 mois de massage gynécologique à la clinique du Dr. Auvard. Arch. de tocol. et de gyn., Tome XXIII., pp. 1, 104, 167, 263, 335.

Lindfors, A. C. Nagra ord om Thure-Brandt's metod och de svenska läkarne. Upsala, Läkareförenings Förhandlingar. N. F., Bd. I., Heft 3-4.

Medd, H. C. Treatment of diseases of women by abdominal massage and electricity. Am. Journ. of Obst., Vol. XXXIV., p. 58.

Schamroeff. Beiträge zur Beurteilung der Thure-Brandt'schen Behandlungsmethode der Erkrankungen d. weibl. Geschlechtssphäre. Journal akuscherstron i shenskich bolesnej, Juli-October.

Stapfer. Kinésithérapie gynécologique, Ann. de Gyn., Tome XLV. ,p. 218.

1897.

Beuttner, O. Ueber gynäcologische Massage in Beckenhochlagerung. Centralbl. f. Gyn., No. 19, p. 544.

Brandt, Thure-. Massage bei Frauenkrankheiten, 3. Aufl., Berlin, Fischer's med. Buchhdlg.

Bratz. Centralbl. f. Gynäcologie.

Monod, E. Massage et troubles urinaires liés aux déviations utérines. Arch. de Gyn. et de Tocol., Vol. XXIII., p. 701.

Schamroeff. Materialien zur Beurtheilung der Thure-Brandt'schen Methode bei Erkrankungen der weiblichen Genitalsphäre. In. Diss., St. Petersburg.

Stapfer, Traité de Kinesithérapie gynécologique (Massage et Gymnastique). Nouvelle méthode de diagnostic et de traitement des maladies de femmes. Préface de A. Pinard, Paris. A. Malonie.

Seligmann. Centralbl. f. Gynäcologie.

Stratz, C. H. Einige Bemerkungen über die Massage in gynäcol. Fällen, Nederl. Tijdschr. voor Verloosk. en Gynaec., Jahrg. VIII., p. 203.

Frumeris, G. de. Massage gynécologique. Paris, 1897, et Am. Journ. of Obst., Vol. 38, p. 427.

Nordhoff-Zung. The Thure-Brandt Treatment in gynecology practically applied. Am. Journ. of Obst., Vol. XXXVI., p. 832.

Ejkmann. Centralbl. f. Gynäcologie.

1898-1899.

Beuttner. Beitrag zur gynecolog. Untersuchung und Massage in Beckenhochlagerung. Wien. Med. Presse, No. 30, p. 1,249.

Colson. Deux cas graves d'exsudat intrapelvien guéris par le massage gynécologique. Soc. Méd. Chir. de Liége, 2, III., Scalpel, 5, III.

Haberlein. Die Massage bei postoperativem Ileus. Centralbl. f. Gyn., 1898, No. 42.

Halbau. Ueber Belastungstherapie. Monatschr. für Geburtsh. und Gyn., Bd. X., p. 128.

Pincus. Die Behandlung entzündlicher, namentlich exsudativer Beckenaffectionen mittelst Belastungslagerung. Gyn. Sect. der Aerzte und Naturforscher. München.

Platon. Massage et involution utérine. Gaz. des hop. No. 67.

Rumpff, W. H. The use of massage in malpositions of the uterus. Am. Gyn. and Obst. Journ., Vol. XIV., p. 256.

Stapfer, H. La kinésithérapie gynécologique, Paris. Masson et Co.

Unterberger. Zur Heilgymnastik und Massage nach Thure-Brandt in der Gynäcologie. Verein für wissensch. Heilkunde, Königsberg, 5. Dec., 1898.

Ziegenspeck. Massage treatment in diseases of women for practitioners. Translated by Westerschutte, Chicago.

Eckgren, Erik. Zur manuellen Therapie in der Gynäc. Inaug. Diss., Berlin.

Findlay. Massage in gynecology. Chicago Med. Standard, July, 1899, p. 227.

Piering. Ueber manuelle Behandlung in der Gynäcologie. Mon. f. Geb. und Gyn., Bd. XI., p. 260.

Silverstri. La kinesitherapia en Ginecologia, Rivista Valenciana de scienc. med., No. 17, Mayo, p. 135.

Palm, R. Ueber die Massagebehandlung bei tubaren Erkrankungen. Monatsschr. f. Geburtsh. und Gyn., Bd. XI.

Hoffa, A. Die Technik der Massage. Stuttgart, Enke.

1901.

Olshausen, R. Zur gynäcol. Massage. Centralbl. für Gyn., No. 3.

Montgomery (Philadelphia). Beckenmassage. Thorapeutic Gaz., 1900, Nov. 15.

Landau, Leopold. Ueber Tubensäcke, Berlin.