scissors, acted on the same principle as Dr. Sims's; it divided only the os externum, so as to open the cavity of the cervix, the part to be cut being first seized between the two blades. The operation was perfectly free from risk; the hæmorrhage was usually slight, and a good os was made. He had performed the operation many times, both in hospital and private practice, and was well satisfied with the results. One advantage of incision over dilatation was, that it relieved the engorgement and inflammation."

Dr. Barnes's admirable paper gave rise to a lengthened discussion; he and Mr. Baker Brown alone, amongst all the speakers, holding the same views that I do in regard to the relative infrequency of contraction at the os internum as compared with that at the os externum.

SECTION V.

THE UTERUS SHOULD BE IN A NORMAL POSITION—*i. e.*, NEITHER ANTEVERTED NOR RETROVERTED TO ANY GREAT DEGREE.

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BEFORE treating of displacements of the uterus, let us first fix in our minds a correct idea of its normal position and relations. Not wishing to write one unnecessary page, I shall, as hitherto, avoid minute anatomical and histological detail, which can be better learned from any of our text-books. I would say, however, that some of the discrepancies of authors may be reconciled when we remember that one speaks of the condition of things in the living subject, and another in the dead. Thus, one will tell us that the uterus is about two and a half inches deep, while another will say it is less. Both are right; for the uterus, an erectile organ, full of blood, is larger and longer in the living body than in the dead. The knowledge of one is gained in the clinic; of the other in the dissecting-room.

I do not know of any anatomical plates that represent correctly the position and relations of the pelvic organs. The artist has not succeeded perfectly in this cut (fig. 89), but it is near enough to give us a good general idea of the subject.

[I was at great pains to get a correct outline of a vertical section of the pelvic bones as here shown. For this I am under special obligations to M. Péan, of Paris, Prosecteur des Hôpitaux, who politely afforded me every facility at Clamart, both in its museums and dead-house;

also to my talented young friend Edward Souchon, of New Orleans, Louisiana, who made for me repeated dissections, which were photographed, and from which Mr. Vien made the drawing.]

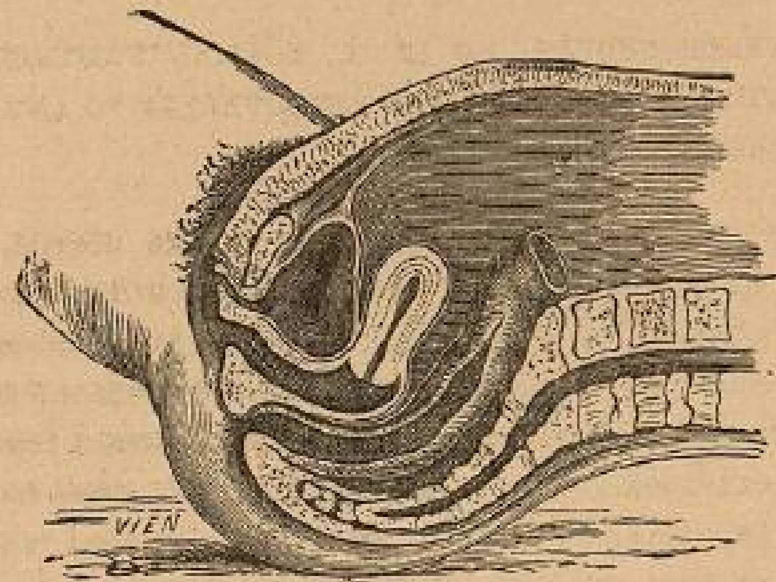

FIG. 89.

The uterus occupies, normally, very nearly a central position in the pelvis, being, perhaps, a little nearer to the sacrum than to the pubes. Its long axis should stand at about right angles to that of the vagina; the fundus pointing in the direction of the umbilicus, and the os tincæ towards the end of the coccyx. The fundus may be tilted a little one way or the other without the position being necessarily abnormal. The condition and contents of the bladder and rectum may temporarily influence it to some extent. If it turn forwards or backwards for 25° or 30°, it does not amount to a malposition; but if to 40° in either direction without soon rectifying itself, it is abnormal, and usually goes from bad to worse, till the malposition becomes persistent. A glance at the cut will show us that if the uterus fall backwards in a line drawn from the os to the promontory of the

sacrum, it will describe an angle of 45°, and will present its broadest surface to the pressure of the superincumbent viscera, which will necessarily force it eventually lower and lower; and if it turn forward to the same extent, the same power exerted on its broad posterior surface necessarily increases this abnormal tendency. But an anteversion never goes relatively to so great an extent as a retroversion, simply because it meets with more resistance. Anteversion often stops at 45°, but may go to 90°, as when we have a complete version, with the whole organ lying flatly down on the anterior wall of the vagina, and parallel with it, while a retroversion seldom or never stops under 90°, and often goes to 135°, simply because there is less opposition to its downward progress.

It then follows that if the fundus of the uterus is found constantly lying just behind, or even near, the symphysis pubis, it is an anteversion; but if it is found lying persistently back under the promontory of the sacrum, it is a retroversion. But when only the body of the uterus is turned forwards or backwards, the os seeming to be in rather a normal relation with the vagina, there is necessarily a bending of the cervix somewhere between the os externum and the os internum, and we call this a flexion. Most, but not all, versions become flexions; so that, as a general rule, they are but different stages or degrees of the same thing. I have not, therefore, thought it of practical importance to say that out of so many anteversions and retroversions, there was such a proportion of flexions, simply because these distinctions will not modify the general principles of treatment.

Time was, and not very long ago, when the diagnosis of uterine displacements was attended with great diffi-

culty, but there is nothing easier now. Formerly, all uterine disease was known under the sweeping term of prolapsus; a term that has been used so vaguely and indefinitely that it should be banished from uterine technology; for in England it is applied to a descent of the organ through the vulvar outlet, while in my own country it is often applied to its various intrapelvic deviations. Formerly, if any woman here had a little vesical tenesmus with a constant sense of weight in the pelvis, and bearing down, it was called a prolapsus; but now we know very well that these symptoms may exist as a sign of engorgement, or granular erosion of the os, without the least displacement of the organ.

To be accurate, then, the malposition should be ascertained exactly, and we should apply to it the term that would express precisely the deviation from a normal position. If we use the term retroversion, of course we all understand it, because its meaning is defined. If we say anteversion, for the same reason, there can certainly be no misunderstanding. If we say antero-lateral version, it is equally significant of the position, provided we add the qualifying adjectives, right or left, as the case may be. If we say procidentia, we mean that the cervix uteri has passed beyond the mouth of the vagina, to a greater or less degree; but to say there is prolapsus is to hide up the real condition of the uterus under a vague generality. I therefore use the terms anteversion and retroversion to designate the relative deviations of the body of the uterus from a normal position while within the pelvic cavity, and the term procidentia to designate its passage out of the pelvis through the mouth of the vagina.

Anteversions are often due to adventitious development of some sort in the anterior wall; retroversions

frequently occur as a sequence of debility, or relaxation in the ligaments that support the uterus. In both we often find an enlargement of that portion of the body which is most dependent. In the first, this enlargement frequently induces the deviation; in the second, it is oftener the consequence of it.

When we remember that about every eighth marriage is sterile, we see the necessity of investigating all particulars that can by any possibility bear upon the elucidation of this important subject. At the beginning (page 2) I said that I had, for obvious reasons, divided my sterile patients into two classes; viz., natural, and acquired sterility. The following table shows at a glance what an influence mere displacements of the uterus must exercise over the sterile condition in each of these classes:—

	No. of Cases.	Anteversions.	Retroversions.	Total Malpositions.
1st Class.......	250	103	68	171
2nd Class......	255	61	111	172
Total	505	164	179	343

Thus we see in 250 married women, who had never borne children, that 103 had anteversion, and 68 retroversion; while in 255 who had once borne children, but for some reason ceased to conceive before the natural termination of the child-bearing period, 61 had anteversion, and 111 retroversion, the sum total in each class bearing almost exactly the same relation to the number observed, being about two-thirds of the whole. Hence we infer that if the malposition exercises an influence to prevent conception in the one class, it is of equal importance in preventing it in the other. The mere position of the uterus is here stated without

reference to causes or complications. I have purposely avoided saying how many of these had granulations, engorgements, hypertrophies, fibroids, ovarian cysts, or other complications. The table shows that two-thirds of all sterile women labour under some form of uterine displacement, without reference to the particular cause of such displacement; and that the anteversions and retroversions in the two classes are in inverse proportion: the anteversions in the first being about equal to the retroversions in the second; and the retroversions of the first nearly the same as the anteversions of the second.

Without further general remarks, let us proceed to consider in turn these various forms of displacement. I have not thought it worth while to make a distinct heading for antero-lateral flexions. They comprise but a small class, and are almost always secondary, being the result of some other affection.

Of Anteversion.—According to the tabulated statement above, nearly one-third of all sterile women have anteversion. In natural sterility the proportion is 1 in 2·42; in acquired, it is 1 in 4·18, being nearly twice as frequent in the first as in the second.

It would here be appropriate to lay down the rules of diagnosis in reference to this particular form of displacement; but as its principles have been already amply stated, whether by bi-manual palpation or probing (see pages 7, 8, and 101 to 105), it is unnecessary to repeat them here. I will now only say that we are never under any circumstances to probe the uterine cavity till we have by the touch first ascertained its probable direction; and then the sound is to be curved or not, according to the suspected curvature of the canal of the cervix.

Anteversion may depend upon a variety of causes; sometimes the uterus seems to be bent upon its own axis, in consequence of an abnormal elongation of the organ. For instance, suppose the sound passes three inches and a half into the cavity of the uterus, we would then say it is at least an inch too long. This must depend upon one of three things: either an elongation of the intra-vaginal portion of the cervix; elongation of the supra-vaginal portion; or hypertrophy of the fundus. If on the first, the touch, sight, and absolute measurement will at once determine it; if on the second, the unerring bi-manual palpation will demonstrate to our sense of touch, a long, delicate, slender, flexible supra-vaginal cervix; if on the third, it can be equally as well measured and judged by the touch alone, provided we apply the principles of diagnosis already referred to.

We sometimes find the uterus undeveloped, entirely too small, often not more than an inch and a half deep; and again, it is not uncommon to find it over-developed, with the supra-vaginal portion of the cervix long and slender; and when this is the case, the fundus must of necessity fall one way or another, and most usually forwards, producing anteversion or flexion.

Again, anteversion seems to be occasionally the result of a shortening of the utero-sacral ligaments; or else these ligaments become shortened by the long-continued malposition. Nothing is more common in old retroversions than to see the anterior wall of the vagina contracted in consequence of the long-continued malposition; and here it often presents a formidable barrier to a permanent rectification of the displacement. Now in the same way it is presumable that the utero-sacral ligaments, if not congenitally too short, may become

shortened by long disuse, just as the round ligaments may become relaxed and lengthened by long error of position.

Be this as it may, we sometimes meet with anteversions where we encounter great difficulty, and inflict great pain in drawing the os tincæ forwards. In these cases the vagina is long and narrow, and the os tincæ, instead of pointing towards the end of the coccyx, may look directly back towards the hollow of the sacrum.

Now, if we here insert a tenaculum into the anterior lip of the os tincæ, and pull it towards the urethra, feeling at the same time unusual resistance to this traction, there will be one of two things to account for it: either the fundus of the uterus is bound down anteriorly by adhesions, or the cervix is held back posteriorly by shortened utero-sacral ligaments. If the first, which is very rare, then it will be impossible to elevate the fundus to a normal position by the usual method of elevating the anterior cul-de-sac of the vagina up behind the inner face of the pubes with the left index finger, while the fundus is pushed backwards by the other hand acting upon it in the hypogastrium through the parietes of the abdomen; but if it be due to the second, then, by introducing the index finger into the rectum, or even to the posterior cul-de-sac of the vagina, at the same time that we draw down the cervix with the tenaculum, we shall feel the utero-sacral ligaments as tense and resistent as two well-stretched guitar-strings. I must admit that such cases are not very common; but their infrequency makes it the more important to be able to recognize them when we meet with them.

One of the most common causes of anteversion is a small fibroid in the anterior wall, as represented in fig. 90. It is very interesting to observe the influence of

such tumours in producing the various displacements of the uterus. If a fibroid not larger than an English walnut is attached in any way to the posterior wall of the uterus above the level of the os internum, it almost invariably pulls the uterus over backwards, producing retroversion; but if a similar-sized tumour is attached to the posterior wall of the uterus below the level of the os internum, whether it be pedunculated or not, it will almost as invariably push the fundus of the uterus over forwards, or produce anteversion. In other words, a small tumour of the body of the uterus posteriorly will produce retroversion, while the same sized tumour of the cervix posteriorly will produce anteversion; and *vice versâ*, a small tumour in the anterior wall of the body anteverts the uterus, but if it grow anteriorly below the

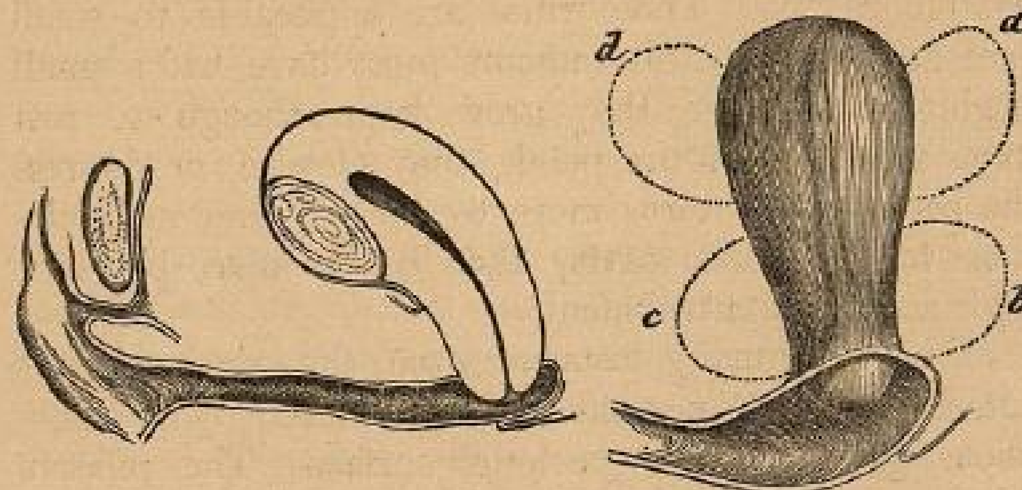

Fig. 90. Fig. 91.

level of the os internum, it invariably retroverts it. The reasons are anatomical and most obvious. Let fig. 91 represent the uterus in its normal relations with the axis of the vagina. A small tumour on the posterior wall at *a* will, as before said, retrovert the uterus, but a similar-sized one attached low down on the cervix at *b* will as invariably antevert it. In the first instance the

uterus obeys the laws of gravity, by which an additional weight on one side of the fundus must pull it in the direction of said force; while in the second instance, the tumour finds a *point d'appui* in the utero-sacral ligaments, rectum, and cul-de-sac of the vagina, which oppose its downward pressure; and thus, as the tumour grows, it gradually pushes the fundus forwards.

For the same reasons a tumour anteriorly at *d*, as a rule, anteverts, while one at *c* invariably retroverts the uterus, because it finds a point of resistance in the walls of the bladder at its junction with the cervix. Another reason for this curious law of displacement in consequence of small growths on the supra-vaginal cervix may be found in the fact that the tumour acts like a splint upon the side of the naturally slender and flexible cervix. These rules are applicable to small tumours only, and all tumours must have had a small beginning. When they grow large enough to rest upon the brim of the pelvis, they elevate or depress the body of the uterus more by their volume and relations to the pelvic cavity than by the mere place of their accidental attachment.

I have in many instances seen the cervix curved anteriorly where it seemed to be produced by an amorphous growth on its posterior surface. The relative position and outline of this anomalous projection is represented in fig. 92, *a*. I do not know what to call it; it is not a fibroid tumour. To the touch it has a fibro-cartilaginous feel: I suppose I have seen a dozen cases of it. It is very uniformly of the shape and form here represented, always pointed below; it almost always projects, as

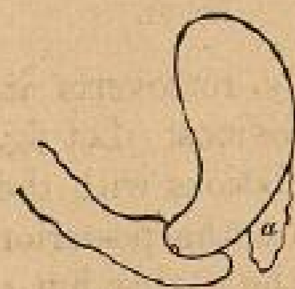

FIG. 92.

here, a little below the insertion of the vagina. I have never found anything like it growing on any other portion of the uterus. I have seen it in two cases in which there was no curvature of the cervix. Each of these was sterile, each had the cervix incised; one conceived four months afterwards, the other in eight. Both of these had had metro-peritonitis some time before I saw them. From these two cases we may infer that this growth may possibly be the product of inflammatory action, and that it does not, *per se*, interfere with conception and child-bearing. In the other instances I could not trace its history to any predisposing cause. The first case of this anomalous growth that I ever saw was in the Woman's Hospital, in 1856, in a young Irish girl, who had painful menstruation as the consequence of a curved contracted cervical canal. Dr. Emmet and myself called it the cock's-comb excrescence. We called it this merely to give it a name. The name was suggested by the form of the growth, by its mobility, by its gristly feel, and by the manner of its attachment.

It has a sessile attachment to the neck of the womb, perhaps half an inch wide above, growing narrower as it descends. It can be diagnosed with the greatest facility by the bi-manual method of palpation. Indeed I never consider any obscure condition of the uterus thoroughly made out till we manipulate the whole surface of the organ almost as completely as if we had it outside of the body. This affection is not described in the books, but I have no doubt that others will find it where they have not, as yet, suspected anything of the sort; and the professional mind once directed towards it, I have as little doubt that some one will be able, some time or other, to give us its pathological appearances from post-obit examinations.

But to return to anteversions. We may have them from other causes. We often see granular engorgement of the anterior lip, accompanied by a corresponding engorgement, or hypertrophy of the anterior wall of the uterus. And here there is always anteversion. Some think that these corresponding conditions of the cervix and body anteriorly are pathologically one and the same thing; but we often see the engorged condition of the os and cervix cured without the least impression being produced, either on the hypertrophy of the anterior wall or on the relative position of the fundus.

We sometimes have the uterus bound down by ligamentous adhesions, the result, most probably, of some former peritoneal inflammation. These cases are comparatively rare; but that they do exist is proved both by observation on the living, and by post-mortem examination. We more frequently find ligamentous adhesions in retroversions than in anteversions.

Of course we can do nothing for the rectification of malpositions dependent upon adhesions, nor as a rule will they require any interference, for the adhesions naturally sustain and support the uterus in its abnormal relations, and protect it against the pressure of the superincumbent viscera, which would otherwise force it still lower in the cavity of the pelvis. In those cases in which I have found the uterus bound down by adhesions, there was little or no complaint of the symptoms ordinarily attendant upon such displacement.

So far as the treatment of the sterile condition in connection with anteversion is concerned, I fear that our efforts must be confined almost wholly to seeing that the os tincæ is open enough, that the cervix is of proper form and size, and that the secretions of the vagina and of the cervix are suited to the viability of the spermatozoa.

The introduction of the uterine sound by Simpson constitutes an era in obstetric surgery. Before this we knew as little about the rectification of displacements as we did about their diagnosis. It was, and is still, used as a redresser of displacements, in retroversions, with much show of science and precision, if not of skill and success; but in anteversions with none of these. As a mere probe, it is, as I have said before, very valuable, although the practised touch seldom needs its aid; but as a redresser, it is capable of doing great mischief, and should no longer be used as such. Even as a probe, merely to determine the course, curvature, and exact depth of the uterine cavity, it is possible to do harm with it.

In anteversion I now seldom ever use it in the dorsal decubitus; but place the patient in the left lateral semiprone position, as for all uterine operations. When the cervix is brought into view, it is pulled gently forwards by a small tenaculum (figs. 14 and 53), and then the annealed probe (fig. 40), more or less curved to suit the previously ascertained or suspected curvature of the canal, is to be introduced with great gentleness. As soon as it passes the os internum, it goes to the fundus almost by its own weight, simply by elevating the handle of the instrument towards the sacrum. We can never do harm or even produce pain, if we adapt the size and curvature of the probe to the peculiarities of the individual case. We may occasionally need one not

FIG. 93.

larger than that shown in fig. 93, and we sometimes need to curve it quite as much in complete anteflexions, such as are represented in figs. 41 and 60.

Putting the cervix on the stretch by means of the tenaculum hooked into the anterior lip of the os greatly facilitates the use of the probe in difficult cases, by fixing the uterus and by straightening the curvature of the canal. I am sure that much harm has been done with the sound; 1st, by having it too large; 2nd, by having it too straight, or always fixed at the same curvature, as shown in fig. 39; and 3rd, by using too much force. Again let me repeat that we are never to forget that it is simply a probe, and that we are to handle it as delicately as we would a probe for any other surgical purpose.

While we then accept the sound as a probe, we must wholly reject it as a redresser. For diagnosis it is valuable; for treatment it is dangerous. During the learned discussion in the French Academy of Medicine a few years ago, on the uses and abuses of this instrument, the fact was fully established, that it had, perhaps more than once, been forced through the fundus uteri, and that death was the consequence of this rude and awkward accident. This could only have happened by using it with violence as a redresser. There is some show of philosophy to justify its use in retroversion, but why it should ever have been used to replace an anteverted uterus I cannot understand; and yet I have seen patients with anteversion, who had for months been subjected to the introduction of the sound almost daily; I need hardly add, without the least benefit.

To replace in this way, or in any other, an anteverted uterus with the expectation of its remaining in a normal position by this means alone, is perfectly futile; for it

invariably falls back into its abnormal position the very moment that the force is removed that replaced it.

For the replacement of an anteverted uterus we need no instrument whatever. The process is simple enough, and is effected easier and better by mere manipulation than by any instrumental aid. The bladder empty, the patient on the back, introduce the left index finger, as shown in fig. 1, to the anterior cul-de-sac; make pressure outwardly with the other hand, to be sure that the uterus is anteverted; then remove the outer pressure, and with the index finger still resting a little anterior to the cervix, elevate the os tincæ in the direction of the pubes, by carrying the anterior wall of the vagina on the point of the index finger up behind its inner face;—this pressure bringing the cervix forwards and upwards, necessarily elevates the fundus from its bed behind the pubes and throws it slightly upwards;—now push the ends of the fingers of the right hand on the outside from above, down into the hypogastrium closely behind the pubes, so that the fingers of the two hands shall feel that there is nothing between them but the thin walls of the abdomen and the thinner walls of the vagina and bladder. While the right hand is thus held firmly, the fingers occupying, as it were, the place just filled by the fundus uteri, quickly slide the left index from the anterior to the posterior cul-de-sac of the vagina, and push this before it till the finger lies snugly up behind the cervix uteri; then elevate it, as it were, against the points of the fingers of the right hand, with which push back the fundus, and retrovert the whole organ while we hold it up almost in contact with the abdominal parietes.

Thus we are able not only to straighten up the

organ, but to manipulate every portion of the external surface of the uterus: the fundus and body, before we attempt to replace it (fig. 1); the remainder by the above manœuvre.

This is ordinarily easily done, even in very fat women, because nature provides a sulcus between the fatty deposit in the walls of the abdomen, and the pubic covering in which the outer hand is readily carried down behind the pubes as above directed.

We only find trouble in delicate, nervous, hysterical women, where there is involuntary spasm of the abdominal walls, or where the cervix uteri is firmly held back by shortened utero-sacral ligaments.

It is by thus passing the left index finger behind the cervix uteri, and then drawing the whole organ directly forwards, almost against the inner face of the pubes, and pushing the ends of the fingers of the outer hand down behind the uterus instead of before it, that we can diagnose with the greatest accuracy fibroid tumours, whether sessile or pedunculated, and such offshoots as are represented in fig. 92, page 236. It was but the other day that a friend of great eminence in the profession asked my opinion in reference to a fibroid suspected to be in the posterior wall of the uterus. He was hesitating whether to attack it through the cavity of the uterus or through the cul-de-sac of the vagina. By this bi-manual method of palpation alone, I was able in a moment to say that the tumour, nearly as large as the fœtal head at term, was pedunculated, and that the pedicle, about an inch long and three-fourths of an inch thick, was attached to the posterior face of the uterus, about half-way between the insertion of the vagina and the fundus uteri (fig. 94). It is not necessary to say more about the peculiarities of the case here, except that in the

course of a few minutes my friend was perfectly convinced of the exactness of the diagnosis.

But to return to the subject of anteversion. So far as the mechanical treatment of anteversion *per se* is con-

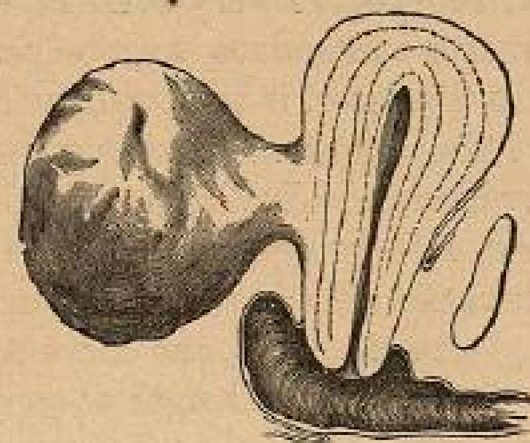

FIG. 94.

cerned, I know of but one instrument that has the power of rectifying the position perfectly and at once, and that is the intra-uterine stem (with disk) of Dr. Simpson. But unfortunately the risks of the instrument are too great; and I know but three practitioners in my own country who have not, after repeated trials, discarded it altogether. These are Professor Peaslee and Professor Conant, of New York City, and Professor Mack, of Buffalo.

In the practice of the Woman's Hospital, Dr. Emmet and myself were long ago compelled to discontinue its use, on account of frequent accidents, such as hæmorrhage, metritis, and pelvic cellulitis. Sometimes a small Meigs's gutta-percha ring will afford relief, not so much by rectifying the position as by elevating the organ slightly in the pelvis, and taking some of its weight from the bladder. Sometimes we derive considerable comfort from a small globe pessary, particularly if it can be made to rest just anterior to the cervix uteri. For

this purpose I have now and then attached a stem to the globe, which projects externally, and is curved up over the pubes, to prevent the ball from running down into the posterior cul-de-sac.

Fig. 95 will represent a very common form of anteversion. Now, if we introduce a globe pessary an inch and a quarter in diameter, it will ordinarily pass to the very bottom of the vagina at *a*, resting there under the cervix, and elevating it, while the fundus will be thereby rather depressed anteriorly than otherwise; thus aggravating the malposition: but if we attach a malleable stem to the globe, and curve it externally at the proper length to prevent it from passing further than the anterior cul-de-sac, its tendency is to throw the fundus upwards in a normal direction by its pressure or traction on the anterior wall of the vagina at *b*. Its action is readily understood by pressing the index finger forcibly up behind the symphysis pubis, which easily elevates the anteverted uterus. If the ball be too large, its pressure here will retrovert the uterus, just as a tumour growing low down on the cervix anteriorly will throw the fundus backwards.

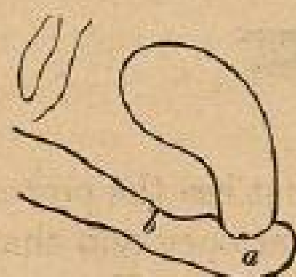

Fig. 95.

But all instruments with external projections annoy and irritate a naturally sensitive nervous system, already rendered more irritable by disease, and are to be avoided if possible.

It was the fashion a short time ago to use a sponge, with a string for its removal. To this practice there are two serious objections: 1st, nothing could be more disgusting than a sponge thus worn for six or eight hours; and 2nd, the sponge always swells considerably by absorbing moisture, and soon patients feel the need of increasing its size, and they generally get to introducing two instead of one. The patient that once contracts the habit of wearing a sponge in the vagina will find it very difficult to break it up.

But what is better than this, and, indeed, better than almost anything of the sort, is the application of a small wad of cotton, not more than an inch in diameter when moderately compressed, which may be used simple or moistened with glycerine, or otherwise medicated. Instead of expanding, it gets smaller by the pressure of the parts. A pessary of simple cotton should never be retained more than twenty-four hours: moistened with glycerine, it may be worn two or three days, or till it come away spontaneously. The cotton pessary secured with a string for its removal, is to be applied by means of a porte-tampon, described and figured further on.

In very aggravated cases of anteversion, where the whole organ lies flatly down on the anterior wall of the vagina and parallel with it, we often, indeed almost always, find the vagina unusually deep, with the anterior wall greatly elongated. For such cases I devised and executed an operation in 1857, which has answered a most admirable purpose.

It was under these circumstances. A lady was sent to me by Professor Josiah C. Nott, of Mobile, Alabama, in December, 1856, who had a most complete anteversion, the fundus uteri being drawn down behind the inner face of the pubic symphysis by a fibroid tumour on the fundus anteriorly. Fig. 96 represents the relative position of the uterus and tumour *a*. I have never seen a more complete anteversion. The diagram does not in any way exaggerate any of the details of the case. She had a cervical leucorrhœa, which was cured in a

few weeks; but the cystorrhœa, vesical tenesmus, and malposition, with its other inconveniences, persisted. For the relief of the displacement I tried all sorts of pessaries, but nothing did any good. The pelvis was

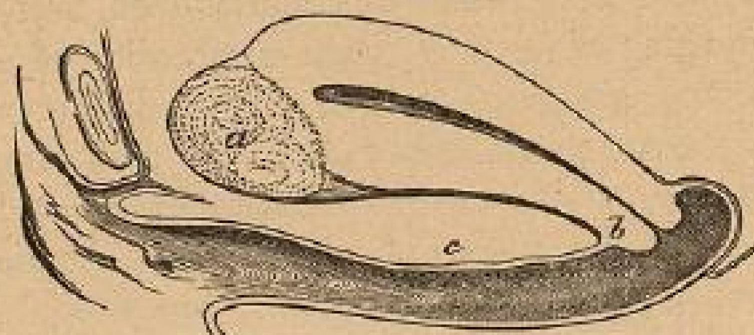

FIG. 96.

deep, the vagina capacious, the anterior wall unusually long, and the uterus laid down on and parallel with it.

I discovered that the malposition could be entirely rectified by hooking a tenaculum in the anterior lip

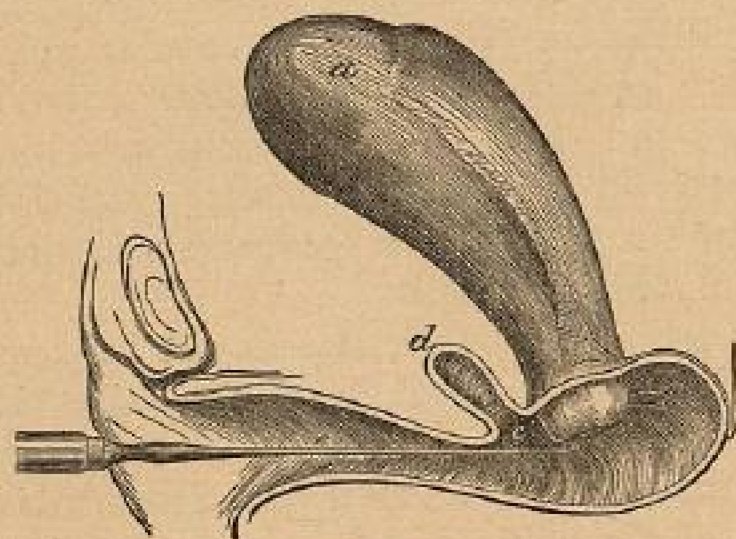

FIG. 97.

of the os tincæ, and drawing the cervix down towards the urethra. By continuing this traction till the cervix was brought forward about an inch and a half, the fundus rose up in the pelvis into rather a normal position, not-

withstanding the weight of the tumour on its anterior portion. When the os tincæ was thus drawn forwards, the elongated, relaxed anterior wall of the vagina was naturally folded upon itself, presenting the appearance of an enormous anterior cul-de-sac, as at *d*, fig. 97.

Under these circumstances, could anything have been more positively indicated than an operation, to retain the uterus in the position in which it was thus held by the tenaculum?

The operation of shortening the elongated anterior wall of the vagina, by attaching the cervix uteri to it at the point *c*, was therefore most naturally a self-suggested affair. It was very simple, and as a mere operation must always be a successful one; whether it will, when successful, always produce relief of suffering, time and further experience can alone determine.

Two semilunar surfaces a half-inch wide, and running nearly across the anterior wall of the vagina, the one in juxtaposition with the cervix, and the other an inch and a half or more anterior to it, were carefully denuded of the vaginal mucous membrane, as shown in fig. 98. They were then closely united by seven silver sutures, as in the operation for vesico-vaginal fistula. The patient was put to bed, and a self-retaining catheter worn for a few days; after which the urine was drawn off when necessary. At the end of ten or twelve days the sutures were removed, the union of the two sur-

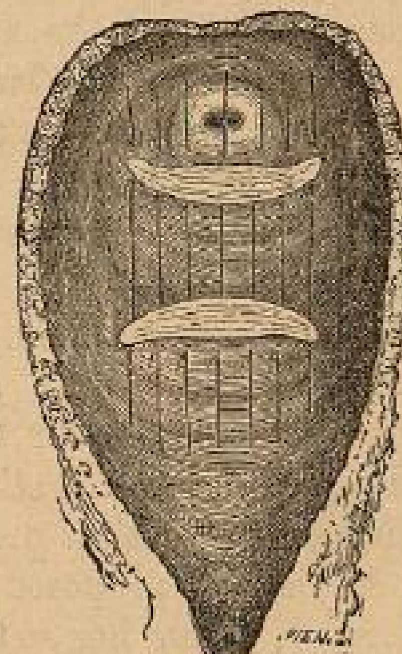

FIG. 98.

faces being perfect. The patient retained the recumbent posture for a week longer, to allow the cicatrix to get strong enough to resist any traction that might be made by the bladder, rectum, or uterus itself.

The uterus was held as nicely in its proper position by this bridle of vaginal tissue as it was previously by the tenaculum; and fortunately she was wholly relieved of the suffering symptoms, of which she had so long complained before the operation.

Twelve months afterwards this lady gave birth to a son. I saw her husband a year after the birth of the child, and he reported his wife as enjoying most excellent health, never having felt the slightest symptoms of her old troubles at any time since the operation. I am sorry to say I have performed this operation in but two other instances. I have seen many cases suitable for it, but they have been satisfied to put up with some clumsy mechanical contrivance rather than submit to an operation. As I have not seen the case above related since the confinement, I cannot say what effect the labour produced on the cicatrix, but I should expect to find it intact.

In 1859, a young lady aged twenty-six was sent to the Woman's Hospital with just such an anteversion as the one above related, except that the fibroid on the fundus of the uterus was much larger. She was a patient off and on for twelve months, and Dr. Emmet and myself exhausted all our mechanical ingenuity (and patience too) without producing the least benefit.

At last I proposed to her the operation above described, telling her at the same time that it had been done but once before. She readily accepted it; and the operation was performed in May, 1860, with perfect success, and with almost entire relief to all her sufferings. I have seen this young lady repeatedly since; the last time in July, 1862, being then twenty-six months after the operation, and the uterus remained just as it was when she first left the Hospital.

I performed this operation a third time in 1860, at the Woman's Hospital; the patient left soon afterwards, and as I have not seen or heard from her since, I cannot say what was its effect upon her health; but the operation, as such, was as successful in every particular as in the other two instances.

I would not be understood as recommending this operation as a universal one in anteversion. It is to be resorted to only when the anterior wall of the vagina is unusually long, and when the uterus lies down parallel with it, presenting the fundus just behind the inner face of the symphysis pubis.

Of Retroversion.—While the table on page 231 shows that about one-third of all sterile women have anteversion from some cause or other, it also shows that another third suffer from retroversion; although these two forms of displacement vary in the two classes of natural and acquired sterility; the anteversions, as before stated, predominating in the first, and the retroversions in the second.

The uterus is retroverted when the fundus falls backwards under the promontory of the sacrum or whenever it passes an angle of 45° in that direction from its normal position. But, as before said, it never stops at 45°, seldom at 90°, and often goes to 135°. Thus we may have different degrees of this version. We can ordinarily diagnose a retroversion by the bi-manual method of palpation, already more than once described; but if at any time we are in doubt, the