removed from prompt medical aid, and where even a small loss of blood is to be carefully avoided.

I have had lately under my care two most obstinate cases of retroversion in which no sort of pessary could be worn except cotton; without the cotton pessary, the uterus in each was turned back to an angle of more than 100° from a normal line, but with this pushed snugly up into the posterior cul-de-sac, the organ was comfortably sustained in position. Each of these patients conceived during the time of using this instrument. They were taught to apply the tampon on rising in the morning, and to remove it on going to bed at night. These are the only cases in which as yet I have seen pregnancy follow the use of this sort of pessary. One of them was a patient of Sir Joseph Olliffe. We tried a variety of pessaries, and were compelled to give up all of them, and resort to the cotton pessary, and the result was as stated.

A year ago, I incised the cervix uteri in a case of dysmenorrhœa where there was a retroversion, with anteflexion, and elongation of the cervix, with induration and great tenderness of its posterior portion, just above the insertion of the vagina. The dysmenorrhœa and the engorgement of the organ were relieved; but the retroversion continued, with its attendant symptoms of pain across the hips, dragging sensations, &c. On account of the tenderness of the cervix when pressed above the posterior cul-de-sac, it was impossible for her to wear any of the instruments that I am in the habit of using. But she could wear a small tampon of cotton with the greatest comfort. She writes: "The uterine support has, I am sure, done great things for me. I now use it about every other day: last month every day. My idea is that it has quite succeeded in its purpose, and that I am as well as any one need be.

Sometimes the broad, flat porte-tampon above figured is difficult of introduction, even in those who have borne children; and then I have been compelled to resort to one made after this fashion (fig. 115). The cotton, which must be properly prepared, is to be pushed in at the open end of the instrument, and this is to be applied as before directed.

Fig. 115.

Of Procidentia.—Whenever the cervix uteri passes through the mouth of the vagina, we call it a procidentia, whether it be to a slight or a great extent. Thus a procidentia may be complete or incomplete: complete, when the vagina is inverted and protruded externally; incomplete, when the cervix uteri alone passes down without bringing the vagina with it. It is only occasionally that we see the cervix alone projecting between the labia for an inch or two, and remaining thus stationary for a long time; usually it goes from bad to worse, till it eventually passes entirely through the vulva, forming a tumour of great size, which, at its most dependent part, presents the os tincæ often ulcerated and bleeding. This tumour is a veritable hernial mass, consisting sometimes of the whole uterus, but oftener of its elongated cervix, the *bas fond* of the bladder, and occasionally intestine, with the inverted vagina as its outer covering.

Fig. 116 represents an incomplete procidentia, and is a type of its class. – See Dr. Bennet's case, on p. 220.

Fig. 124, p. 305, represents a complete procidentia, and may be taken as a type of its class.

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

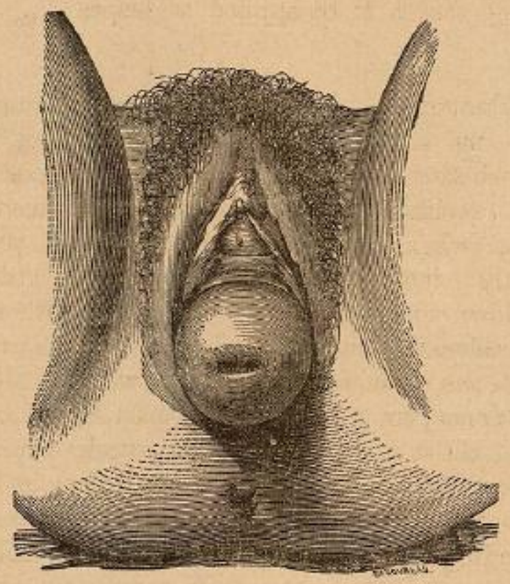

Fig. 116.

of an irregular mass of fibroid tumours, which fill the pelvis and crowd the uterus down; but not even then without the co-operating conditions above cited.

In very old cases of procidentia, the vagina, from long exposure to the air, becomes dry, and assumes

almost a dermoid appearance. It is the opinion of many, that the cervix uteri is the first in the order of exit, that it always comes down, to open like a wedge the parts through which the whole mass descends. I cannot say that this is not so at first, but I can with the greatest confidence say that it is not so in the great majority of cases, when they become chronic.

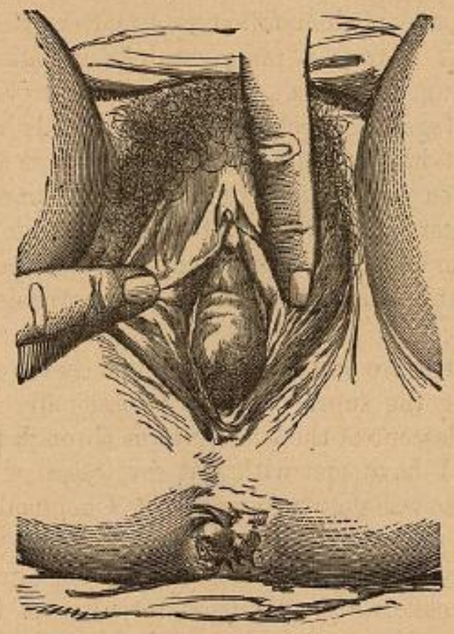

Fig. 117.

In an old procidentia, the vagina attains enormous proportions, in consequence of its being constantly expanded by the distending power of its hernial contents. To observe the order of descent in a case like this, reduce the parts to their normal relations, and let the patient force them out again, whether in the erect

posture or on the back, and we shall see the anterior wall of the vagina, first forced downwards against the perineum, in the form of a cystocele; a slight straining pushes this beyond the vulva, and the cervix follows immediately, bringing down the posterior wall of the vagina. If we would reduce a procidentia with ease, we must invert this order; push back the posterior cul-de-sac first; then the cervix; and then the anterior wall of the vagina and bladder follow as a matter of course.

Fig. 117 is from a photograph of a patient of Dr. Thierry-Meig, in Paris, and represents a cystocele as the first stage of procidentia. By a little effort she could effect its complete protrusion. She is a German, twenty-three years of age, the mother of three children, the youngest being five months old. She is a street-sweeper, and has had procidentia ever since her last confinement. Besides this she has hæmorrhoids, as seen in the cut.

Sometimes we find the intra-vaginal cervix elongated, but oftener the supra-vaginal. Occasionally we see a complete descent of the whole uterus through the vulva. However, I have met with but few cases of this sort. One of these was shown to me by Dr. Chepmell, of Paris. It was the case of a maiden lady, some forty years old, who had been subject to it for twelve or fifteen years, and often suffered greatly from retention of urine, and the other ordinary attendants of this affection. The doctor tells me that he has repeatedly found the procidentia girdled by an ulcerated sulcus at its neck, and seemingly bordering upon the verge of sphacelus, in consequence of its obstructed circulation. Its great peculiarity consisted in the fact that the uterus was but one inch and a half deep. Many eminent medical men had seen the case before, and were of opinion that the

utero-cervical canal was obstructed at this depth by some mechanical barrier that prevented the further passage of the probe; but we were able to settle this point very easily, by palpation alone, while the uterus was in the pelvis; and when it came down, it passed entirely through the vulva, and we could easily grasp it between the two hands, by passing the index-finger of one hand into the rectum, and hooking it forwards over the fundus, while pressure was made by the other on the front of the tumour, just below the urethra. Indeed we could even tilt the fundus downwards and backwards across the long axis of the procidentia; and this movement gave us great facility in diagnosing the contents of this great hernial protrusion, which consisted of intestine as well as of uterus and bladder. In this case the vagina was immense, the perineum greatly relaxed, and the pubic rami unusually divergent.

But while we only occasionally find a procidentia thus associated with a uterus, under or even of normal size, we often find it where there is hypertrophy of some part of this organ. For instance, there may be hypertrophy of the cervix, or merely elongation of its intra-vaginal portion, or of the supra-vaginal portion; if the former, the body of the uterus may be of normal proportions; if the latter, it is more apt to be hypertrophied. And sometimes the cervix is elongated in its two segments, both infra and supra-vaginal.

In these cases of cervical elongation, we often find the utero-cervical canal four and five inches deep; the supra-vaginal portion of the cervix being slender, attenuated, and, when examined per rectum, feeling not larger than the finger. This elongation is evidently secondary. I believe it to be a sequence of the procidentia, for we are more apt to find supra-vaginal elongation where the

fundus uteri is from some cause or other too large to pass out of the pelvis. If the body of the uterus passes out of the pelvis, there is no supra-vaginal elongation; if not, there is; and for the simplest reason. Suppose the cervix uteri projecting through the vulva, the fundus, from some cause, cannot follow, but remains fixed, as it were, within the pelvis by hypertrophic or fibroid enlargement; the cervix once through the vulva, pressure around it from above soon pushes down the two culs-de-sac, resulting in a *de facto* hernia. This gets larger and larger, and the uterus retained in the pelvic cavity becomes one of the principal points of support for this mass, which hangs by the cervix, and the cervix consequently becomes not hypertrophied but attenuated and elongated, feeling like a mere cord, not more than half its normal size. And this elongation is gradually produced by these two antagonistic forces; one acting on the body of the uterus to retain it in the pelvic cavity, the other on the lower end of the cervix, to push it downwards.

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

Fig. 118 represents a procidentia of more than twenty years' standing, in a woman nearly seventy years of age, whose pelvis was filled with a number of small fibroids of bony hardness. One large tumour is not so apt to produce procidentia as several smaller ones, say from the size of an orange to that of the fist, loosely bound together; because the single one may grow large enough to rise above and rest upon the brim of the pelvis, while the smaller ones accommodate themselves to the pelvic cavity, displacing whatever may interfere with their development. The above was the largest hernial procidentia I have ever seen. It reached nearly half-way down the thighs, and contained a large quantity of intestine. When it was reduced she felt less comfortable than when it protruded. On this account no effort was made for its relief.

Huguier has written extensively on procidentia

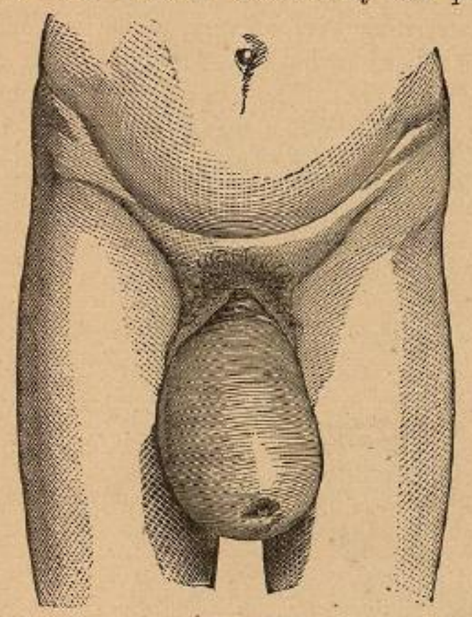

Fig. 118.

uteri, and I believe he was the first to point out the distinctive characteristics of its anatomical peculiarities. He found elongation of the cervix in all cases, either above or below the insertion of the vagina; and he suggested and performed amputation of the neck of the uterus in every case, and with great success. For

special information in regard to his views, I must refer the reader to his memoir.*

I amputate the cervix only when its lower segment is too large or too long, and projects so far into the vagina as to present a mechanical obstacle to the retention of the uterus *in situ* when replaced. This will be sufficient in some cases, such as that met with by Dr. A. K. Gardner, of New York, who amputated a cervix weighing ʒiv. ʒij. ɔij., which is, perhaps, "the largest on record as having been removed during life."† Dr. Gardner says, "The organ drew up far into the vagina after the portion was removed, and in order to arrest a persistent hæmorrhage it was necessary to draw it down into view with hooks." Of course all such cases as this are readily cured by amputation, and, as a rule, it is the only thing to be done. But this is not a type of the great class of cases that we are called upon to treat. If there should be elongation of the infra-vaginal cervix, amputation is the remedy; but we often find procidentia without any extraordinary elongation of the infra-vaginal portion of the cervix. There is then nothing to amputate.

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

* "Mémoire sur les Allongements hypertrophiques du Col de l'Utérus dans les Affections désignées sous les noms de Descente, de Précipitation de cet Organe, et sur leur traitement par la résection, ou l'amputation de la totalité du Col, suivant la variété de la Maladie." Par P. C. Huguier, Membre de l'Académie Impériale de Médecine, &c. Paris: J. B. Baillière et Fils. 1860.

† "Amputation of the Cervix Uteri." By A. K. Gardner, M.D., Prof, &c. &c.

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

I propose now to give a brief sketch of the steps by which we arrived at the method of operating herein advocated.

In 1856, Dr. Warren Stone and Dr. Axson, of New Orleans, referred a patient of theirs to my care, who had had procidentia for three years. She was about thirty years of age, tall, slender, and bony, and had enjoyed good health till the yellow-fever epidemic of 1853, in New Orleans. The labour, lifting, and fatigue which she underwent as a nurse during that terrible epidemic left her with a double inguinal hernia and a complete procidentia uteri. I have seldom seen a more distressing case. She wore a double truss for the hernial protrusions; and, for the procidentia, the largest globe-pessary that I ever saw. But notwithstanding the immense size of the globe, which was nine inches in circumference, it was impossible for her to retain it in the vagina by any bandage; so it was constantly slipping away, and that too at rather inopportune moments. I arranged a pessary with a stem and a T bandage, which kept the parts within the pelvis. In the course of two months she had regained some 25 pounds of flesh, and was on the eve of returning home harnessed up with trusses and bandages to a most uncomfortable degree, when I happened to ask her if she would be willing to submit to a surgical operation, if we could promise to get rid of the pessary and its bandage. She promptly replied, "Yes."

Previously to this we had been in the habit of per-

forming the perineal operation after the plan of Mr. Baker Brown, and for some reason we had not been successful. Dr. Emmet and myself both thought that we could hardly promise any better success by it in this case than we had formerly met with. This was the first time that I had had a good opportunity of observing and studying the manner in which the procidentia occurred. After replacing it and allowing it to descend again, which always occurred very quickly on assuming the erect posture, I noticed, as before described, that the descent was not at first by the protrusion of the cervix uteri, but invariably by a prolapse of the anterior wall of the vagina, which always preceded the cervix, and drew down the uterus. I found that this cystocele was but another hernia (she had double inguinal hernia), and I discovered that she could not force it down again, when simply the point of the index finger was held in the anterior cul-de-sac. Then by pinching up the anterior wall of the vagina into a longitudinal fold, with two tenacula or a pair of forceps, I saw that the parts had no tendency whatever to come down; and that it was impossible for our patient to force them down if we thus prevented the anterior wall of the vagina from descending. Hence the idea of wholly removing the redundant portion of the anterior wall of the vagina occurred to me; but it did not occur to me to operate simply by removing strips of vaginal mucous membrane. I seriously proposed to this lady to make a complete vesico-vaginal fistula, by removing at once, as it were, a large portion of the base of the bladder with the anterior wall of the vagina. She agreed to it; and I laid the plan of operating before the Consulting Board of the Hospital, and it was adopted. The vagina and its outlet were enormous. When the patient was placed on the knees,

or on the left side, with the perineum elevated by the speculum, it presented about the relative proportion shown in fig. 119. The measurements made repeatedly by Dr. Emmet and myself, gave the following propor-

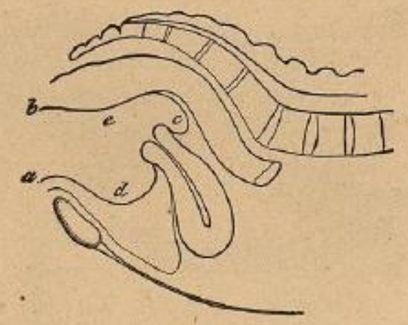

Fig. 119.

tions. From the meatus urinarius to the perineum, *a* to *b*, when this was pulled back by the speculum, was three inches; from the meatus urinarius to the posterior cul-de-sac, *a* to *c*, five inches and a quarter; broadest transverse diameter, four inches and a quarter; broadest antero-posterior, *d* to *e*, three inches and a half.

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

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

Fig. 120 would represent a side view of one blade,

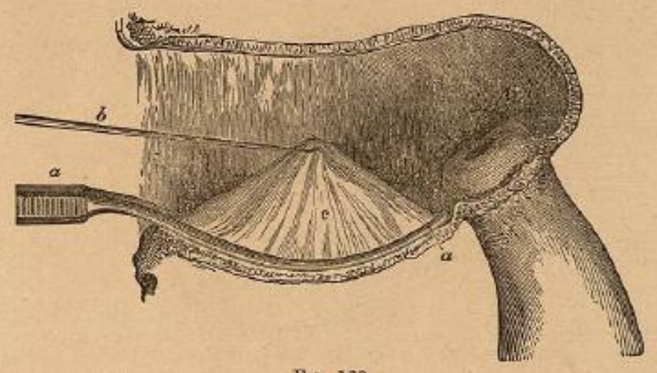

Fig. 120.

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

Fig. 121 would represent about the relative proportion of vaginal tissue here removed. The lateral edges

were brought together longitudinally by seven or eight silver sutures passed transversely, as represented in the diagram. She was soon well, and is so to this day. The operation was done nine years ago. The good

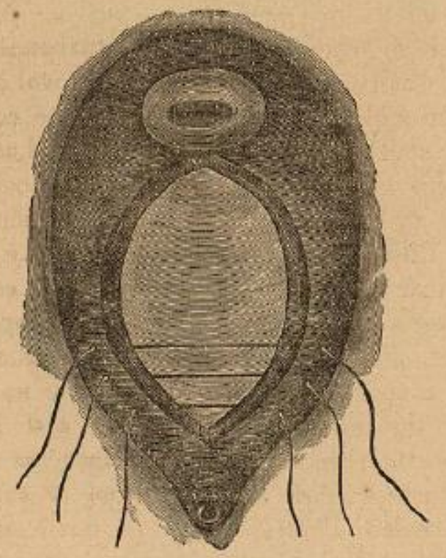

Fig. 121.

result in this case led me to operate on others afterwards, by a simple denudation of the vaginal epithelium to the same extent as shown above. One great objection to this method was, that the necessarily tedious scarification permitted the loss of too much blood; another was the danger of an abscess forming in consequence of the central part of the scarified portion not being closely embraced by the sutures. For instance, it will be seen by reference to the diagram, that when the sutures were closed, bringing the outer edges into apposition, the central portion of denuded tissue not included by them would necessarily be thrown into a

fold that would project the mucous membrane of the bladder into a sort of longitudinal ridge along the *bas fond*. I was at first afraid that this loose tissue might not be held firmly enough together to unite by the first intention; and in one instance an abscess formed that gave rise to some constitutional disturbance. But its nature and seat being detected, the removal of a suture at the upper angle of the wound, near the cervix uteri, promptly evacuated the matter, and relieved all suffering. However, this method of operating was continued till 1858, when an elderly woman, with an enormous procidentia of fifteen or twenty years' standing, was sent to the Woman's Hospital, by Dr. Duane, of Schenectady. It was a very bad case indeed. I operated by the plan of simple denudation of the mucous membrane over a surface extending from the neck of the bladder to the neck of the uterus, and being two inches and a half in its largest transverse diameter; the lateral edges were united by silver sutures, and the parts healed kindly. But I did not remove tissue enough, and there was a considerable cystocele left. I felt pretty sure that the original trouble would be reproduced, unless she should wear constantly some sort of a pessary. Accordingly I fitted one, and sent her home in a very comfortable condition. I was quite satisfied, and so was my patient; but when she got home, the physician who had had charge of her case before she consulted Dr. Duane, ridiculed the idea of her being cured by a surgical operation, if it were necessary for her still to wear an instrument afterwards. Although she was perfectly comfortable, she returned in two or three months, and asked to be readmitted to the Hospital. She said she wished simply to prove to her physician at home that she could be cured by an

operation, so as not to be compelled to wear a pessary. Her pluck challenged my inventive faculties, and then it was that I devised another method of operating. For instance, instead of the broad scarification of the anterior wall of the vagina, as before, I simply removed the mucous membrane in the form of a V (fig. 122, *a b*), the apex being near the neck of the bladder, and

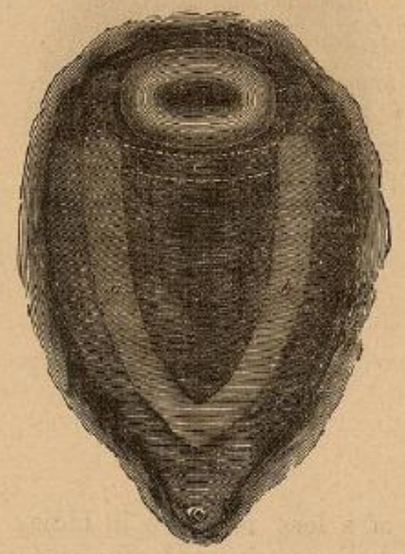

Fig. 122.

the two arms extending up on the sides of the cervix uteri. These two denuded surfaces were brought together by silver sutures passed transversely, thus making a longitudinal fold narrowing the vagina and crowding the cervix backwards. This simple operation was thus repeatedly performed, and always successfully, by Dr. Emmet and myself, at the Woman's Hospital, from 1858 to 1862, when I left New York.

In Paris I had occasion to perform it for Sir Joseph

Olliffe on an old lady sixty-five years of age, who had had procidentia for twenty years. The parts united; the uterus was held in its place, and she returned home in a fortnight. Her general health was very feeble, in

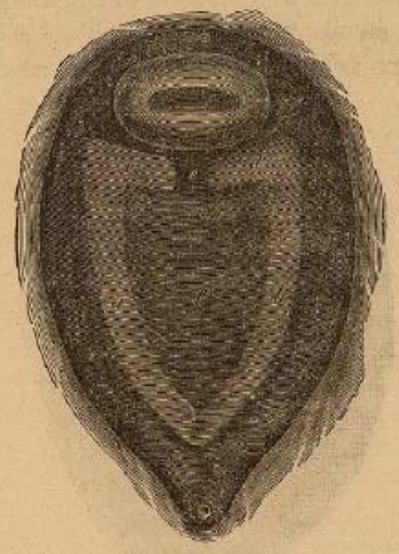

Fig. 123.

consequence of a long residence in India; and in two months the whole cicatrix gradually gave way, and the procidentia was reproduced. This was the first and only case of failure that I had ever seen after this method. The operation was subsequently repeated; but this time, instead of a V-shaped scarification, it was made in the form of a trowel, as represented in fig. 123, the point presenting below, the shoulders above in the anterior cul-de-sac. The denuded surfaces *a c* and *b d* were brought together by transverse silver sutures. A small portion of tissue was left undenuded at *e*, between *c* and *d*, for the purpose of permitting the escape of

any secretions naturally forming in the shut pouch *f*.

Although she is an opium-eater, and frequently has attacks of diarrhœa, in consequence of its inordinate use, as we often see, the operation was successful, and the uterus still remains in its normal position. This last operation was performed with the assistance of Sir Joseph Olliffe and Dr. Johnston, of Paris, and Professor Pope, of St. Louis.

Dr. Emmet* has recently called attention to a source of trouble when the operation is performed by a simple V-shaped denudation, as shown in fig. 122. He says, "Previous to the time of Dr. Sims's removal to Europe in 1862, we both had operated frequently without the necessity for any modification occurring.

"In September, 1862, after three months of great suffering, one of the first patients operated on by Dr. Sims in this manner, presented herself at the Hospital, for relief. She stated that, during four years, she had been entirely relieved by the operation, when, suddenly (while in the act of lifting) she was seized with a persistent tenesmus, greatly aggravated in the upright position.

"On examination, the line of union was found perfect, with no prolapse of the vaginal wall. But the neck of the uterus had slipped behind the septum into the pouch, thus throwing the fundus into the hollow of the sacrum, and fixing the organ in this position. With great difficulty, the neck was disengaged. On returning the uterus to its normal position, immediate relief was

* *New York Medical Journal*, vol. i., No. I. April, 1865. "A Radical Operation for Procidentia Uteri." By Thomas Addis Emmet, M.D., Surgeon to the Woman's Hospital.

obtained, and she was discharged without further treatment." This case was subsequently operated upon by Dr. Emmet.

After this, Dr. Emmet hunted up two patients upon whom he had operated eighteen months before, and he found the uterus retroverted in each one, with the cervix resting behind the pouch made by bringing together the two denuded surfaces *a b*, fig. 122. To remedy this defect, in his subsequent operations he simply denuded the vaginal mucous membrane in a line across the cul-de-sac between these two points, as shown by the dotted line *c*, fig. 122, making a regular triangle with its apex at the neck of the bladder, and base at the cervix uteri. In January, 1864, Dr. Emmet operated on a very unruly patient, who, during the night after the operation, "got up and walked about the ward for several hours, and continued, in spite of all remonstrance, to follow her own inclination. On the twelfth day, it was discovered that four sutures (near the neck of the bladder) had torn out, and through the gap a portion of the relaxed base of the bladder protruded. The sutures were all removed at the time, and every hope of success abandoned. Before her discharge, it was found on examination that the entire line of union had gradually parted, with the exception of the cross scarification, in front of the cervix uteri. The fold thus formed (as in a sling) had retained the organ perfectly in place, although below, a cystocele existed. Future experience must demonstrate how far the formation of this fold can alone be relied on under other circumstances; yet it is evident that in many cases this will prove all that is necessary to retain the uterus *in situ*."

It is always interesting to watch the slow degrees by which true principles of treatment are established. The

idea of narrowing the vagina for the cure of procidentia was first suggested by Marshall Hall, but I do not know that the operation ever succeeded. Then I carried out the principle by cutting away the whole of the redun-

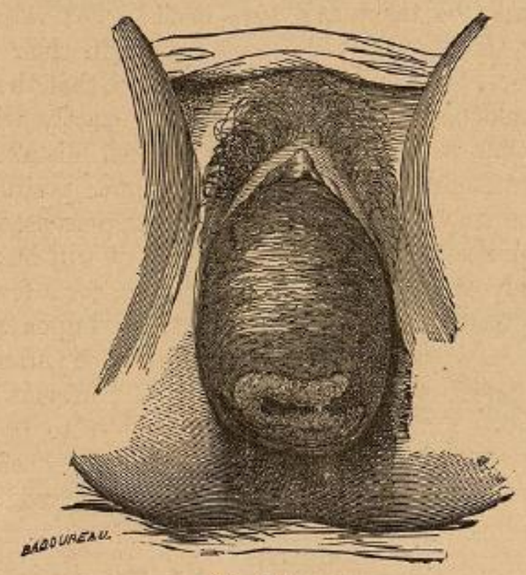

Fig. 124.

dant portion of the anterior wall of the vagina (fig. 120). This I afterwards modified by simply denuding a large oval surface on the anterior wall, and uniting its lateral edges by silver sutures. This was further modified by making a V-shaped scarification (fig. 122), and producing a veritable fold in the wall of the vagina. Then I made the V trowel-shaped, by turning its upper ends inwards across the axis of the vagina, in Sir Joseph Olliffe's case, fig. 123. Then Dr. Emmet made this a complete triangle, and eventually an accident showed him that merely a narrowing of the vagina just

at the anterior cul-de-sac, at least in one case, answers every purpose of holding the uterus in its place.

The mechanical execution of this operation is a matter of some nicety, but it is by no means difficult. Suppose we have such a case as the one represented in fig. 124, which may be taken as a type of its class; we wish to narrow the vagina to keep the parts in their normal relations. We would suppose, *à priori*, that the operation could be done more easily and exactly with the uterus thus protruded; but it is a great mistake. The uterus must first be restored to its proper position, and if the os tincæ is ulcerated, as here represented, or if the vagina is dry, scaly, and skin-like, it will be well to apply glycerine on a tampon of cotton, for a few days, till the ulcerations are healed and the vagina assumes more of a normal appearance; after which the operation may be performed. For this purpose, the patient is to be placed on the left side, as so often before described, with my speculum introduced to pull back the perineum and posterior wall of the vagina. We can then get an accurate idea of the dimensions of the over-distended vagina, and with a small tenaculum hooked into the mucous membrane on each side of the middle line of the anterior wall, we can approximate these surfaces, and thus determine whether we should make the denudation of tissue to a greater or less extent on either side. There was at first some little trouble in making the two arms of the V equilateral; sometimes one would diverge a little more from the median line on one side than the other;

Fig. 125.

but this was overcome by using an ordinary malleable uterine sound curved as represented in fig. 125. Its convexity rests centrally along the middle line of the anterior wall, the distal end pushes back the cervix uteri, while the counter-curvature lies in contact with the urethra. By thus pushing the neck of the uterus back in a straight line, while the anterior wall is depressed centrally, the curvature of the sound is hidden from view by the lateral folds of the vagina, which fall over it and meet in the middle line, showing us exactly where the tissue is to be removed for the purpose of uniting the parts that thus so naturally and easily come together. With the parts thus held, it is very easy to denude two surfaces a third of an inch wide or more, extending, seemingly, almost in parallel lines from the neck of the bladder upon each side of the cervix uteri. To make the transverse line of denudation join the upper ends of these two arms of the V, we remove the curved sound and pull the cervix downwards with a small tenaculum.

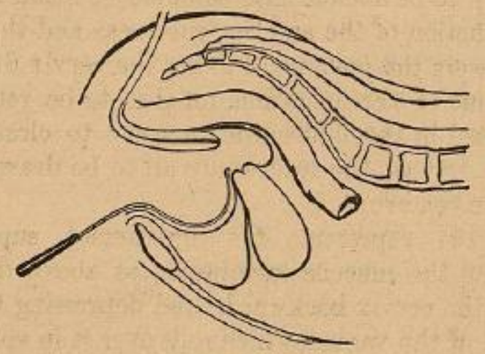

Fig. 126.

We must be careful not to make the arms of the V too divergent, and at the same time we must avoid running

them too closely together. They should, when united by sutures, relieve the cystocele without putting the parts too much on the stretch. The sutures are, of course, to be passed transversely, beginning below, as represented in fig. 121. The sound is to be retained, pushing the uterus backwards till we come to pass those near the cervix uteri. These should be made to embrace all the denuded tissue, *c d*, excluding the undenuded portion *e* (fig. 123). I think it very important to leave a drain here, as before said, for the discharge of the normal secretions of the pouch *f*.

Fig. 126 represents the speculum in position, and the curved sound pushing back the cervix and depressing the anterior wall of the vagina.

Dr. Emmet bends the end of the sound into the form of a ring, to fit around the cervix uteri. Sir Joseph Olliffe suggested the same thing to me when I operated on his case in Paris, but instead of this I have had simply a little tenaculum fork at the end of the instrument (fig. 125), to be hooked into the mucous membrane, just at the junction of the anterior cul-de-sac and the vagina. This answers the purpose of fixing the cervix during the whole time of the operation, for it is to be retained, as represented in the figure, till we come to close up the sutures. Indeed, the sutures are all to be drawn closely before we remove it.

Fig. 127 represents the instrument superficially transfixing the mucous membrane, as above described, pushing the cervix backwards and depressing the anterior wall of the vagina, which rolls over it in voluminous folds, forming a deep central sulcus, along the borders of which the denudation is to be made, and which should be more or less divergent, according to the peculiarities and necessities of the individual case.

When the operation is finished, the patient is to be put to bed, the bowels are to be constipated for a week, with a dose or two of some form of opium in the twenty-four hours; the bladder is to be emptied by catheter

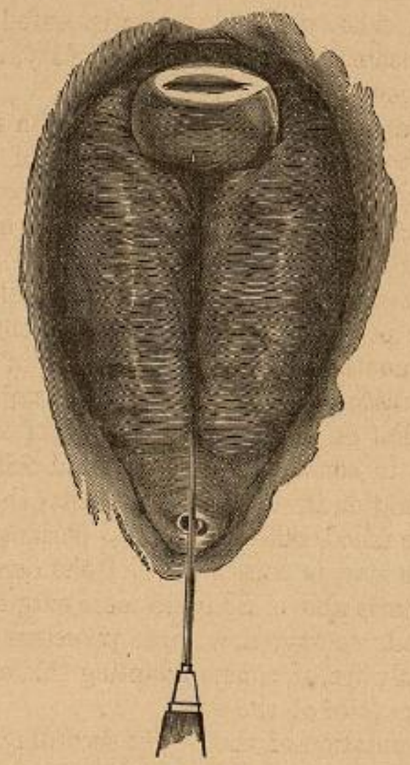

Fig. 127.

when needed, for two or three days, and the recumbent posture is to be enjoined for two or three weeks. The lower sutures may be removed in eight or ten days; the upper should remain a fortnight, unless there is some special reason for their earlier removal. The patient is usually discharged at the end of a month from the time

of the operation, sometimes sooner. I consider this operation one of the safest in surgery. I never saw any serious accident from it, and never saw it fail but once, and that was in the case of Sir Joseph Olliffe's patient (page 302), who was subsequently cured. I have operated repeatedly on patients over sixty, and on two that were seventy years of age.

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

It is not my intention to draw a parallel between this and the perineal operation for procidentia. I only wish to add another resource to our means of permanent cure in this distressing affection. I may state, however, that I was first driven to the expedient of working out this process in consequence of repeated failures of the perineal operation in my hands: not that the operation, as such, ever failed, but that the new perineum made by it often gave way, in consequence of the persistent pressure of the parts above. So far as mere surgical resources are concerned, we have now three processes from which to choose; always, of course, adapting this choice to the peculiar exigencies of the case.

1st. Amputation of the cervix according to the plan of Huguier, when its infra-vaginal portion is too long. I have often seen procidentia cured by this alone. The case of Dr. Bennett, related on page 220, is an example.

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

3rd. The operation of narrowing the vagina by the trowel or triangular-shaped denudation on its anterior

wall, as herein illustrated, and as performed by Dr. Emmet and myself.

But we occasionally meet with those who are so ill-advised as to object to any surgical operation whatever. What then are we to do? Meigs's ring and Hodge's lever utterly fail to do any good whatever; globes, disks, and inflated air-bags all fall out; and Zwang's pessary is the only mechanical apparatus that promises any benefit; and in old women this cannot be tolerated on account of the excessively delicate condition, after change of life, of the vaginal mucous membrane; for as life advances, the vagina becomes more and more intolerant of any foreign substance. Under these circumstances, the best pessary is simply a small tampon of cotton, wet with glycerine, which may be introduced in the morning, to be worn all day. With the porte-tampon, figured on page 285, it is easy enough for the patient to do this every day for herself.

In April, 1865, Dr. Johnston, of Paris, asked me to see a case of procidentia, in a French laundress, about forty years of age, where there was an enormous hypertrophy of the cervix uteri (two inches in diameter), due to the development of numerous little cysts in its substance, varying from the size of a grain of wheat to that of a garden pea. Some fifteen or twenty of these were opened, discharging a ropy honey-like fluid; the uterus was then replaced, and a tampon of cotton wet with a solution of tannin in glycerine was applied. This dressing was repeated every other day for a month or two, when she became so comfortable that she did not desire the operation for a radical cure. When she stops the use of the tampon, the uterus descends on lifting a heavy weight or taking a long walk, but she can now protect herself perfectly against this

accident by applying the cotton pessary with the porte-tampon.

In 1853, Professor Fordyce Barker, of the Bellevue Hospital Medical College, wrote a paper on the treatment of procidentia by the use of tampons wet with a solution of tannin. Considerable success attended this method in his hands, but it seemed to fall into disuse. Perhaps the porte-tampon, as in the case above, may assist to re-instate the practice. When patients will not submit to a radical operation, I have no doubt that this plan may answer a good purpose, even if it does not cure the case permanently.

I had the honour of presenting a paper on Procidentia at the November meeting (1865) of the Obstetrical Society, which formed the basis of an extended discussion. At this meeting, Mr. Spencer Wells called my attention to the fact, that Marshall Hall's idea of narrowing the vagina was put into execution by the late Mr. Heming, and that at least one case had been successfully operated upon. The report of this case may be found in Heming's translation of Boivin and Dugès (1834), page 53, and is dated November, 1831. It affords me pleasure to make this correction.

SECTION VI.

THE VAGINA MUST BE CAPABLE OF RECEIVING AND OF RETAINING THE SPERMATIC FLUID.