places the uterus forwards in a similar manner, causes retention of urine, and carries the vaginal canal forwards, compressing it. But there is a difference in the feel of the tumor manifest to the practised touch; the history is different; the symptoms have usually come out gradually. The sudden shock of hæmatocele and the attendant peritonitis are wanting.

4. *A retro-uterine gestation-cyst.*

5. *Perimetric inflammation.*—The invasion of this affection is sometimes very similar to that of hæmatocele; indeed, it may be concluded that in some cases of presumed perimetric inflammation there is hæmatocele as well. The characters of perimetric inflammations have been described in the preceding chapter. It is enough here to repeat that the seat and nature of the tumefactions felt in the vagina and rectum differ from those of hæmatocele. They are rarely so purely retro-uterine; they are commonly lateral, often unilateral; they fix the uterine neck lower in the pelvis, and generally near the centre, or deviate it to one side; they are more knobby, irregular in shape; they are hard, brawny. But in one case Nélaton found the walls of a hæmatocele hard, like cartilage; and Madge describes the same condition. Retention of urine is more exceptional, and in the issue not blood, but pus is voided.

6. *Abscess in the neighborhood of the uterus.*—This may be distinguished by the following differential signs: Abscess is rarely so distinctly retro-uterine as hæmatocele. In all the cases I have seen which gave rise to doubt there was some degree of laterality. It is not so frequently connected with menstrual accidents; there is no coincident metrorrhagia. It does not attain suddenly its greatest intensity. The tumor is not formed from the commencement. The skin does not suddenly become anæmic. The mass, hard at first, becomes later soft and fluctuating, the contrary being usually the case in hæmatocele. The constitutional symptoms follow an inverse order from those of hæmatocele. But I have known pelvic abscess cause retention of urine.

The diagnosis may in some doubtful cases be assisted by the exploratory needle, or Dieulafoy's aspirator-trocar. The finest puncture may set up inflammation; and if the blood have coagulated, the negative result might betray the inexperienced explorer into the error that the tumor was not a hæmatocele. In the case of a hæmatocele, the blood drawn commonly resembles that taken from the uterus in cases of retained menses. It is treacly and dark-colored. Should pus escape, the diagnosis of abscess is tolerably certain.

I am tempted to add Dolbeau's picture of the diagnosis:—

"The diagnosis," says Dolbeau, "is sometimes very easy, at others very difficult. Great importance must be attached to the more or less advanced stage of the malady. If the case is seen at the commencement, you must bear in mind that hæmatocele is not the only uterine malady whose onset is sudden. The lypothymic symptoms, the pain and distension of abdomen, occur in both pelvic peritonitis and in intense ovarian congestions. Ovarian congestion and hæmatocele are never accompanied by fever. Pelvic peritonitis, on the contrary, is a malady essentially febrile. (But it is to be borne in mind that pelvic peritonitis and its attendant fever not seldom form an ulterior stage of hæmatocele.)

"*Position of tumor.*—In hæmatocele it gives rise to a projection just above the pubes, and sometimes almost reaches the umbilicus. The tumor in pelvic peritonitis never extends beyond the level of the symphysis, or if it does, it extends slowly; whereas, in hæmatocele, the tumor suddenly attains its maximum, and afterwards diminishes rather than increases.

"The excessive pallor of the face, so important a symptom in hæmatocele, is never seen in pelvic peritonitis.

"The *direction of the cervix forwards belongs exclusively to hæmatocele.*"

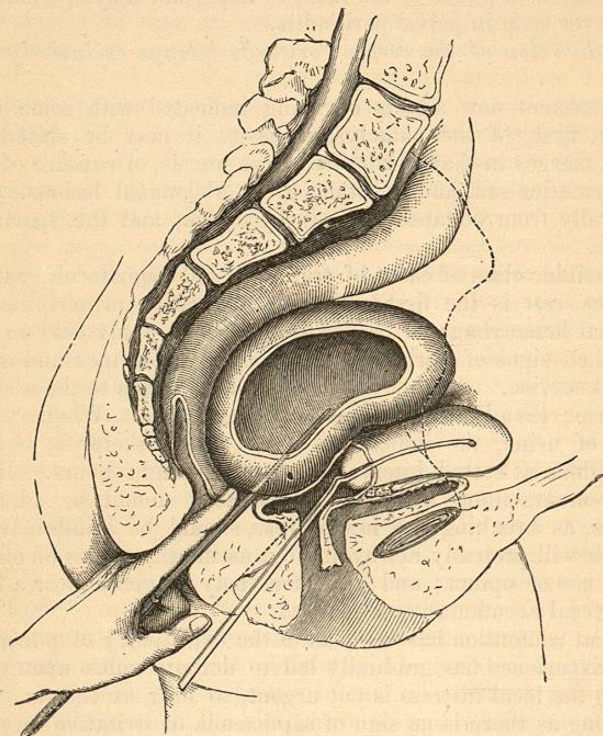
The *treatment* now admits of being indicated with some authority. Disposing, first, of the cataclysmic cases, it may be stated that the treatment merges in that of rupture of the uterus, of rupture of an extra-uterine gestation-sac, and of other great abdominal lesions. We must seek to rally from collapse by rest, by opium, and the sparing use of stimulants.

In the milder class of cases of true encysted hæmatocele, as in all the other cases, *rest* is the first and most imperative prescription. If we suspect that hemorrhage is proceeding, we may apply cold to the abdomen. When signs of peritonitis are coming on, salines and opiates are of eminent service. As topical applications, leeches to the abdomen are often of use; then hot cataplasms or fomentations. Whenever there is retention of urine, the indication to use the catheter is obvious. It should be done at stated intervals—say every eight hours. If there is tenesmus or dysentery an opiate suppository should be administered. Purgatives, as breaking the law of rest, should be sedulously avoided. The bowels will probably act by-and-by, as in other cases of obstruction, under the use of opium; and an enema may be given after a few days, when the fecal accumulation is marked.

The great contention has been as to the expediency of puncturing the tumor. Experience has gradually led to definite rules upon this point. So long as the local distress is not urgent, so long as the tumor remains hard, so long as there is no sign of septicæmia or irritative fever, so long is it wise to follow the expectant method, observing strict rest, and abstaining from all local interference. But when the tumor softens, when it enlarges immoderately, when the pulse and temperature rising indicate septicæmia, then it is time to consider the resort to puncture. This step being resolved upon, we have to weigh the method of performing the operation. The most convenient spot to select is the most bulging part behind the cervix uteri in the roof of the vagina. We must use a medium-sized trocar or a bistoury. But the best instrument is the long tube carrying a knife designed by me, which can be fitted to the aspirator. The instrument should be plunged in the direction of the axis of the pelvic brim, parallel with the posterior wall of the uterus. This line can be accurately defined by first passing the sound into the uterus. (See Fig. 111.) We thus get a landmark. If the instrument be directed obliquely backwards, it is apt to perforate the rectum first, and to enter the hæmatocele obliquely, affording only an imperfect escape. It is well to leave the canula *in situ* to serve as a drain, or to pass in a coil-tube through the tube-canula. If the blood be in great part coagulated, we

may scoop out what can be easily reached with the handle of a spoon; but generally it is wiser not to meddle too much. In some cases it may be more convenient to puncture by the rectum, as shown in Fig. 111. An excellent way of opening the cyst is by the galvanic knife or Paquelin's cautery-knife.

Fig. 111.



This figure is intended to show the relative position of the uterus and rectum and intervening cyst. The sound in utero having settled the position of the uterus, the trocar is thrust as nearly *parallel* as possible to the posterior wall of the uterus. The dotted line behind the sound shows how the perineum is held back by the finger during the use of the instrument. The direction of the os uteri, looking downwards and *backwards*, should be compared with that of the os uteri, the figure of retroflexion in which the os is tilted a little *forwards*. (R. B.)

In cases where decomposition arises, the sac should be washed out twice a day with Condy's fluid, or weak carbolic acid.

Out of fifty-three cases of recovery tabulated by Tuckwell, thirty were treated without any operation. The remaining twenty were punctured. But it is at least doubtful whether in some of these latter the puncture was not superfluous, whether, indeed, it were not a source of danger.

One source of such danger is the admission of air into the sac, and the consequent decomposition of its contents. Aran records a case of this kind in which puncture was made by an exploratory trocar, a fistulous opening remained, and death ensued from putrid infection.

Here, as in all other pelvic and abdominal inflammations, it should be

a standing rule to *avoid repeated examinations.* Manipulation must disturb parts which above all things require repose; it can hardly fail to irritate and aggravate inflammation; it may burst the blood cyst, and lead to a fatal renewal of hemorrhage and peritonitis.

CHAPTER XXII.

DISPLACEMENTS OF THE UTERUS, GENERAL PROPOSITIONS: DEFINITION; VARIETIES OF: PROLAPSUS DESCRIBED; HYPERTROPHY OF THE VAGINAL-PORTION; OBLIQUE OR LATERAL DISPLACEMENTS: ELEVATION; DEPRESSION; ELONGATION BY STRETCHING AND PRESSURE; DISLOCATIONS OF UTERUS BY EXTERNAL PRESSURE; VERSIONS AND FLEXIONS; ANTEVERSION; ANTEFLEXION; RETROVERSION; RETROFLEXION.

Few subjects in medicine have exerted keener controversy than that of displacements of the uterus. Some dispute the reality of these displacements; others dispute their frequency or their importance. The first order of disputants, who simply deny what they have failed to recognize, chiefly consists of those who do not avail themselves of the necessary means to recognize the physical condition of the pelvic organs. To deny the existence of displacements of the uterus without physical examination is as unreasonable as it would be to deny displacement of the heart or of a joint without physical examination. And there is something more than unreasonable in the pretension of those who, thus refusing to examine for themselves, repudiate the experience and authority of others who speak with knowledge.

All who are in the habit of examining the pelvic organs when they show signs of distress recognize the clinical fact that displacements of the uterus are not only real but frequent.

But amongst those who admit this clinical fact, there prevails a diversity of opinion as to the primary and essential, or the secondary importance of these displacements. I hope to evolve satisfactory conclusions upon this question in the progress of this chapter.

We may usefully start with the following propositions:—

1. The uterus is naturally a mobile organ, possessing within the limits of health a considerable range and variety of motion. (These natural movements are described at p. 37.)

2. These natural limits are liable to be overstepped under the sudden or repeated or continuous application of undue force acting upon a uterus increased in bulk or weight, or imperfectly sustained by failure of its natural supports.