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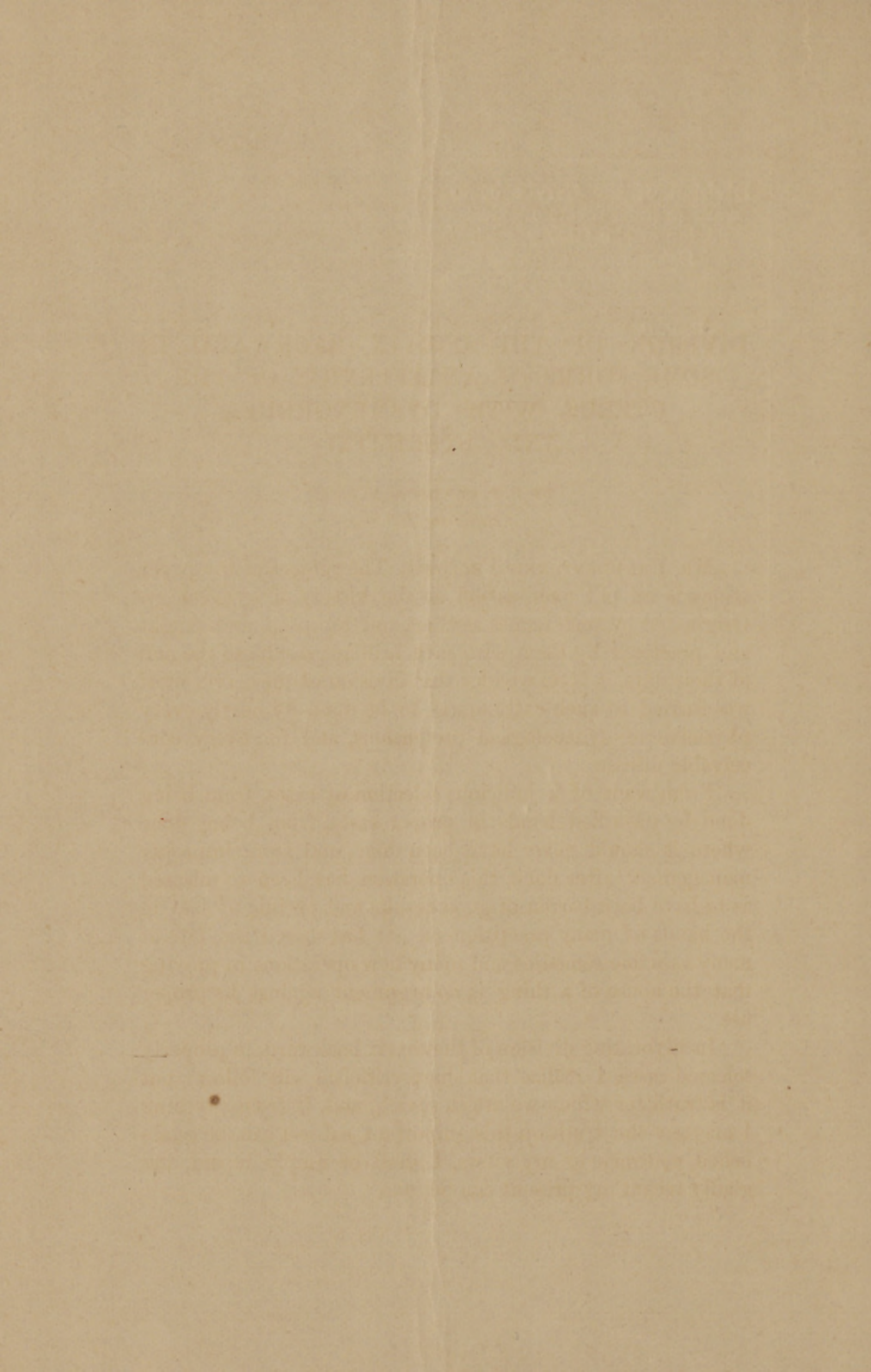
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DIVISION OF THE CERVIX BACKWARD IN
SOME FORMS OF ANTEFLEXION OF THE
UTERUS, WITH DYSMENORRHEA
AND STERILITY.

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MR. PRESIDENT AND FELLOWS: The subject of my paper to-day is an old one—as old as the history of gynecology. Originated by such names as Sims and Simpson, and taught and practiced by them with such brilliant results to the end of their days, it is no wonder that division of the cervix uteri was carried to such extremes as to be done by nearly every physician of gynecological pretensions, and for every conceivable disease.

From want of a judicious selection of cases, from being done by unskilled hands in proper cases, from being done where it should never have been done, and from improper management after done, this operation has been so misused as to have been barren of good results and prolific of bad in the hands of many practitioners. It has shared the fate of many valuable remedies and many new operations in proving that the abuse of a thing is no argument against its proper use.

In advocating division of the cervix backward, in properly selected cases, I realize that sharp criticism will follow; but it is truth for which we are in search, and, if from anything I may say the truth on this important subject can be established contrary to my views, I shall be amply repaid, and gladly recant my present convictions.

Since so many of my professional brethren have turned down this operation, they have been floundering from post to pillar in search of the best means to retain open a contracted cervical canal and stenosed os, and straighten a bent uterus.

Tents, glass plugs, hard-rubber stems, bougies, and steel dilators have their advocates; but, after full trial of them all, I have found not one so safe and so efficient as the knife in the class of cases to which I shall call your attention.

The cases in which I especially recommend this operation are :

1. Those of anteflexion of the uterus, with an elongated, indurated cervix, where the body is bent upon the neck, or the neck upon the body, or where they are bent upon each other, thus forming a more or less acute angle at the internal os.

2. Those cases of not such acute flexion, but where the cervix is hyperplastic and indurated, as blue as a mulberry and as dense as cartilage.

3. Those cases where there is a hard and unyielding band, encircling and constricting the internal os, through which the probe passes with difficulty, and gives to the hand the sensation as if passing over rough and dense cartilage, while the finger of the other hand in the sulcus, between the body and neck in front, gains the impression of a strong cord tied around the uterus at the point of union between body and neck.

The conditions described in the third class are frequently found in the first, and are occasionally present in the second; and, in typical cases of anteflexion of the uterus, where the knife should be used in preference to other remedies, all of the lesions above described are co-existing.

Nearly all such cases are sterile. The very rare exception proves the rule.

In all these cases we find the Nabothian and utricular glands hypertrophied and indurated, so that the probe, in passing from the external os along the cervical canal and through the internal os into the cavity of the uterus, feels as

if it were passing over the surface of an Osage orange, instead of a soft and pliant mucous membrane.

No dense, unyielding cervix should be forced open, and, if so, it will be done with far greater hazard than could accrue from a clean incision with a sharp knife and scissors. All accidents from cutting are the result of improper after-treatment. Accidents from forcible stretching are the immediate result of the force employed. Accidents from tents, plugs, and stems follow from septic poison, or long-continued irritation in an organ, naturally rebellious of foreign bodies within its cavity.

For straightening the uterus, and overcoming a contracted internal os, with its accompanying dysmenorrhea and sterility, the tent is the most dangerous of the above remedies; but, when the patient luckily escapes the critical secondary results, it is the most efficient except the knife; and I do not hesitate to say that we had better cut again and again than use the harsh means advocated by some to dense and unyielding tissue.

A clean cut into the cervix uteri and through the internal os, under proper antiseptic precautions, with proper treatment afterward, and exemption from meddlesome manipulation for a reasonable time, is not more dangerous than a similar cut elsewhere, and nothing to compare to that from the tent, steel dilator, or stem. It is much the most efficient, much the least shocking, and much the most rational of all remedies for rectifying an anteflexed uterus, such as I have described.

Moreover, simple dilatation is not sufficient to rectify an anteflexed uterus with a contracted internal os or with a hyperplastic cervix. To expand and contract is a part of the natural life of the uterus. We see it expanded from two and a half to thirteen inches in pregnancy, and the os sufficiently dilated to transmit the head of a twelve-pound child; and yet we see that same uterus contracted again to three inches, and flexed and stenosed at the internal os, so that the smallest uterine probe enters with difficulty, while the patient

suffers from dysmenorrhea and future sterility. I have perfectly cured several such cases, after they had borne children, by cutting the cervix backward and the internal os backward and forward.

This is the surest means of rectifying an anteflexed uterus in any of the conditions described in the early part of this paper. Simple dilatation will not do. The uterus is sure to contract and retract to its original bend. It is true that strong steel dilators may tear the tissue, but, to say nothing of the violence done to such rigid parts, and the dangers arising therefrom, they are as liable to tear wrong as right, bilaterally as posteriorly, and thus we may complicate the case with a bilateral laceration of the cervix.

An anteflexed uterus, with stenosis at the internal os, and all the accompanying troubles of the intra-uterine mucous membrane, is not put in any better condition by dividing the cervix bilaterally, but is usually left in the same, if not in a worse state, than before the operation. The uterus still remains anteflexed, and the neck bending upon the body, or the body and neck bending upon each other, as effectually closes the os to the exit of the uterine secretions as if the cervix was not patulous from the division. In addition to this, the bilateral incision, if at all extensive, usually leaves the cervix in the condition of a bilateral laceration.

Not so where the cervix is divided backward. All who have done the posterior section know of its tendency to close, and the success of such an operation depends greatly on the skill of the operator in causing it to heal without too great closure.

Again, by the posterior section and division of the stricture at the internal os, backward and forward, the circular muscular fibers of these portions of the uterus are rendered powerless, and, the longitudinal fibers being in full force, the body is pulled up, and the cervix is pulled back; and, even where this operation fails to fully straighten the organ, it leaves it with a straight and open cervical canal into its cavity, instead of a tortuous and obstructed one, and thus there

is a free outlet to the menstrual flow, as well as to the secretions of the uterine mucous membrane between the monthly periods.

These secretions are, to a greater or less extent, retained in the cavity of an anteflexed uterus during the intervals of menstruation, and become acrid, and irritating to the mucous surface. They are a prime cause of the hypertrophy and induration of the utricular glands, with inflammatory thickening of the intra-uterine mucous membrane.

With this factor added to the semi-labor pains of dysmenorrhea every month, and the obstruction to proper circulation and innervation by the constriction at the seat of flexion, I am not surprised to find in nearly every case of decided anteflexion that the Nabothian and utricular glands are as hard and prominent as the rough surface of an Osage orange.

To overcome this diseased condition of the endometrium, it is not only necessary to relieve the stricture at the internal os, but also to straighten the organ, or at least, to give a free and straight outlet from the uterine cavity.

I maintain that rapid, forcible dilatation with any of the numerous uterine dilators, or the slower dilatation with tents, or bougies, or glass or hard-rubber plugs, will not accomplish the desired results alone, in a large number of cases, and will not accomplish them as efficiently in any as a judicious use of the knife, with proper after-treatment.

I maintain further, that keeping up the above remedies for any length of time is apt to produce hyperplasia and induration of the cervix, thickening and induration of the Nabothian glands and cervical mucous membrane, and chronic endometritis, and, in the end, does not accomplish what the knife will for dysmenorrhea, sterility, and the multitude of reflected nervous disorders.

Division of the cervix backward up to the vaginal junction, and the internal os backward and forward, is the only operation from which we are likely to get satisfactory results. I would discard the bilateral section, the taking out of

a V-shaped portion from the posterior lip, Fritsch's method of making four cuts into the external os, and connecting these with a circular incision, by which uterine tissue is removed, as the core from an apple, and also the modification of this operation, by which four cuts are also made through the internal os, and a glass plug inserted, to be worn for weeks or months. The glass plug effectually corks up the cavity of the uterus, and, on its removal after such a length of time, the operator is fortunate if he has not all the results that follow a foreign body in any organ.

None of these methods will straighten an anteflexed uterus, nor give a free and direct exit from the uterine cavity. It will remain bent as before, and the cervical canal and internal os will be crooked and obstructed, as can be seen by bending a roll of paper upon itself. Moreover, by any of these methods, an amount of cicatricial tissue will be left which greatly exceeds that from the posterior section, and this is one of the chief difficulties against which we have to guard in division of the cervix.

Let me say here, that I have never seen good from any pessary for an anteflexed uterus in the conditions described in the beginning of this paper. Any mechanical contrivance which pushes upward and backward the body of the uterus will necessarily carry upward and forward the indurated and constricted cervix to just the same extent; so that the relation of body and neck to one another is unaltered. It has the same bend, the same stricture, the same stenosis. It has grown so, and the conditions arising therefrom are best rectified by the knife, in the blood-letting, the suppuration, the innervation, the paralyzing of the circular muscular fibers of the uterus, and in relaxing the stricture at the internal os. These results follow the division of the cervix backward from the internal os to the vaginal junction.

As I have said before, every anteflexed uterus of long standing, with an indurated cervix and stenosed and strictured internal os, has hypertrophied and indurated Nabothian and utricular glands and a diseased mucous membrane from

os tincæ to fundus uteri. Whatever means we use to straighten the organ, overcome the stenosis, and give a free outlet from the uterine cavity, and however successful we may be in our efforts to this end, we will fail in curing a large proportion of such cases if we do not follow up our surgery with local medication to the diseased endometrium and judicious constitutional treatment. The patient should be allowed to thoroughly recover from the operation, which usually requires one month. She should then be allowed to return to her home, or absent herself from all treatment for one month, except such means as may be used to improve her general health, amuse her mind, and brace up her nervous system. Under this plan the intra-uterine mucous membrane will improve, and will be ready to receive the local treatment, which shall carry on the patient to full restoration of health.

In cases of years' standing, this will not be accomplished in months. No patient should undergo intra-uterine medication for a longer time than one or two months, and she may require to return to the gynecologist two or three times after intervals of two or three months' rest before the desired end is attained.

The best remedy for these diseased conditions of the cervical and corporeal mucous membrane is Churchill's tincture of iodine, freely painted over the whole surface two or three times a week, and followed by pads of cotton soaked in glycerine.

Iodine internally should be given at the same time, and everything done to improve the general health.

This plan of treatment can not be successfully instituted till, by the preceding operation, the cervical canal has been permanently straightened and opened, to allow the free introduction of iodine and the free exit of all uterine secretions.

I know that some distinguished gynecologists are opposed to any intra-uterine medication, and deny its power for good; but I am just as sure of the therapeutical value of this plan of treatment to this mucous membrane as I am of the benefit

to be derived from local treatment to any diseased mucous membrane in the body.

My first operation for anteflexion of the uterus was done on May 28, 1868. The lady had been married five years, was sterile, and suffered with great dysmenorrhea. The cervix was indurated and conical. The internal os was hard and contracted, so that a fine probe was introduced with difficulty. The body and neck were bent upon each other, and, at the seat of flexion, the sensation in front to the finger was as if the uterus was encircled by a firm, constricting band.

Under chloroform, with scissors, the cervix was divided backward up to the vaginal junction. Sims's uterotome, with a very narrow, blunt-pointed blade, was forced through the internal os, and the stricture here was divided backward, bringing the incision outward and backward into that made by the scissors. The knife was then reversed, and the internal os was split forward at the point of flexion. After the cessation of hemorrhage, the incision was packed with small pledgets of cotton soaked in Monsel's solution and water, and the vagina was tightly tamponed. In two months the patient conceived, and, at the end of nine months, gave birth to a fine child after an easy and natural labor.

Since then I have performed this operation about four hundred times.

I am doing it more frequently now than ever before, because, after an experience of eighteen years, I have found nothing in the class of cases described which ultimately gives me such good results and is so free from danger.

I have never lost a patient whose death could be attributed to this operation.

In my early experience, from injudicious and too meddling after-treatment, I frequently met with cases of pelvic cellulitis and peritonitis, which brought some of my patients near to the grave; and they only recovered after weeks or months of severe illness. For many years I have had no such accidents to follow this operation. I have learned to cut my patients, and let them almost absolutely alone for ten

days or two weeks, and then to manipulate them with great gentleness and caution.

I have had a case of severe pelvic cellulitis from simply passing a probe for diagnosis. I have lost one patient from the use of tents, after the greatest antiseptic precautions and rest, and I have had a number ill from peritonitis and cellulitis following tents. These accidents show that, after the uterus has undergone such an operation as section, it should be placed absolutely at rest till it thoroughly recovers from the shock and the inflammation and suppuration which follow, otherwise dangerous symptoms may result.

Dr. William T. Howard informs me that Dr. Roberts has reported one death in a series of eleven cases of forcible dilatation of the uterus, and that he has had one death in a much larger number of cases.

When this operation is to be performed, any pre-existing cellulitis should be wholly removed by previous treatment. The bowels should be thoroughly emptied. Then, under an anesthetic (with the patient on a table in front of a good light, and with a Sims' speculum in the vagina), a tenaculum should be firmly fixed in the anterior lip of the os uteri, and never be removed till tamponing of the vagina begins. The uterus should be gently pulled forward, so as to make its tissues a little tense and to fix its position. With one blade of a pair of straight scissors up the cervical canal, and the other blade behind the cervix up to the junction of the vagina with the uterus, a quick cut should be made through the posterior lip of the cervix, and immediately a second cut, to divide that portion which had slipped from the blades of the scissors in bringing them together the first time. Sims' uterotome, with a very narrow, blunt-pointed blade, should then be passed through the internal os; and, as it is brought out, with the cutting edge backward, the internal os should be freely divided, and the cut prolonged backward into that made by the scissors. The cutting edge of the knife should then be reversed, and the internal os divided forward. Having determined beforehand to what extent we desire to

open the internal os, a sound of this size is introduced. If it goes in freely, the cutting is completed; if not, one or both the incisions should be deepened till the sound passes readily. We should not now be in too great a hurry to apply dressings, but should let the parts bleed freely, only interfering with the hemorrhage in case of accidental division of the circular artery, which must be secured by ligature or torsion. When bleeding has completely or nearly stopped, a roll of cotton (two and a half inches long, and thick enough to fill the opening at the internal os), on a sliding applicator (and previously dipped in a mixture of Monsel's solution of iron, glycerine, and carbolic acid), should be passed through the internal os. The applicator should then be withdrawn, so as to leave half the cotton in the uterine cavity and the other half in the cervical canal. Upon this are packed small pledgets of cotton, squeezed out of Monsel's solution and water (one of the former to two of the latter), until the cervical canal and cut surfaces have been accurately tamponed. Over this is placed a wad of cotton soaked in glycerine, and then the whole vagina is carefully tamponed with wads of cotton squeezed flat out of cold water.

The patient is then lifted into bed, kept perfectly quiet, and not allowed to sit up for eight or ten days. At the end of two weeks she is allowed to step about her room a little, in three weeks she is permitted to walk about the hospital, and in four weeks to walk out on the street. The bowels are not disturbed, nor the dressings removed till the third day, when she is lifted on a table, and in the semi-prone position, with a Sims' speculum and pair of dressing forceps, all dressings are removed. A pledget of cotton soaked in glycerine, with a string attached, is then placed against the os uteri, and is pulled away by the patient the following day. This simple dressing is continued every other day for a month. A gentle purgative is given on the third day, and, if necessary, every day afterward. From absolute rest such patients are usually constipated.

All manipulation of the uterus is punctiliously avoided

for two weeks and more if there is any uterine irritability. I then commence by passing the sound very carefully every other day for a week, and follow this every second day by gently stretching, with my steel dilators, the internal os, so as to prevent undue contraction from cicatrization.

If you perform this operation, and interfere with it too soon, or if you let it go on to healing and cicatrization without interfering at all, or if the operation when well is not followed up by judicious intra-cervical and intra-uterine treatment, it had better never be done.

By this operation I have cured more cases of sterility than by all other means put together; and, in the class of cases described in the early part of this paper, no treatment is so efficient in relieving the dysmenorrhea and the reflected nervous symptoms arising from the pathological lesions above described.

There are cases of sterility and dysmenorrhea, originating in other conditions of the uterus and its appendages, which this operation does not benefit, and for the relief of which it should never be undertaken. Let me repeat one case in illustration :

Mrs. P., aged thirty-four, was sent to me by Professor John Stage Davis in April, 1880. From early girlhood she had been in the habit of bathing her feet in cold water every morning, never stopping for the menstrual period when it came. This occurred at the age of fourteen, with great pain. Menstruation recurred regularly afterward, but with such intense pain, and so profusely, as to compel her to keep her bed during each period, up to the time of coming to me.

At nineteen she had an attack of bilious intermittent fever, and then was seized with severe headache for the first time. After this she was never free from headache for one day during fifteen years, or until she came under my care. The headaches were sometimes on one side, sometimes on the other, and sometimes in the top or front of the head. These were greatly intensified at each menstrual period, and worse as the flow came on. She was reduced to a skeleton. Her nervous prostration

great. Professor Davis had exhausted the best medical skill for her relief without any success. She had been married thirteen years and never been pregnant.

I found her with an anteflexed uterus, the neck bent upon the body, and the body upon the neck.

There was much hyperplastic enlargement of the cervix. It was dense and hard like gristle. The probe showed the uterus to be two inches and three quarters deep. It passed with difficulty through the internal os, as if passing through a gristly stricture. The Nabothian and utricular glands were hypertrophied and indurated, and felt with the probe as if it were moving over the surface of an Osage orange.

She was very anxious for children, but had long since given up all hope of them. Her great desire was for the relief of her constant, and at times intolerable, headaches and excruciating dysmenorrhea.

With such a uterus, and of so long a standing, what could be done to relieve this wretched woman? for this organ was clearly the cause of all her troubles—her dysmenorrhea, her reflected neuralgic headaches, her wasted frame, and her melancholia. Her nerve-supply was so much expended on the uterus that there was little to give to other organs, and they all suffered more or less functionally.

The indications were :

1. To relieve the stricture at the seat of flexion, and give a free outlet to the uterine secretions and menstrual flow.
2. To remove the cervical hyperplasia.
3. To restore the intra-uterine mucous membrane to a healthy condition.

For such a case I had nothing to offer but division of the cervix backward up to the vaginal junction, and the internal os backward and forward ; and, when well from this operation, to follow it up with intra-uterine medication and judicious constitutional treatment. I frankly told the lady that the hope of conception was remote. I could promise nothing certainly, but advised her either to submit to this operation, or have nothing done.

In April, 1880, she was given chloroform by Dr. Robert T. Wilson, and I performed the operation as described in the fore-

going pages. Her recovery was uninterrupted, and she returned home in a month, with directions as to hygiene, and a tonic and alterative constitutional treatment.

From the time that I operated her headaches and dysmenorrhœa became less and less, and wholly disappeared in a short time.

She returned to me four times after this, at intervals of about four months, when I mopped out the uterine cavity with Churchill's tincture of iodine every other day, for two or three weeks, and painted the cervix with the same. She took a pill containing iodine, quinine, and strychnia three times daily for months.

One year after the operation she had a miscarriage, and two years and eight months after the operation, and nearly sixteen years after marriage, she was delivered of her first child, now a healthy, beautiful little girl.

I might go on to report very many similar cases in which dysmenorrhœa, sterility, and numerous nervous disorders have been cured by this operation, but I have already taxed your patience too greatly, and will claim your indulgence no longer.

