

THE INDICATIONS FOR VENTRAL SUSPENSION OF  
THE UTERUS.\*

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Ventral suspension should not be confused with ventral fixation which consists in fixing the anterior face of the fundus of the uterus by a more or less broad surface to the anterior abdominal wall, and producing a permanent adhesion of considerable area. That operation, especially where the peritoneal surfaces are scarified, holds the organ permanently and immovably close up against the abdominal wall. Ventral suspension differs from this in that the posterior face of the fundus is drawn up against the anterior abdominal wall by two silk sutures, and adhesion between the two peritoneal surfaces occurs only at the point where the sutures are tied. Consequently the area of adhesion is not extensive if the sutures are properly inserted and include only the peritoneum and sub-peritoneal fascia of the abdominal wall, for this pulls away from the other structures, as does also the grasp of the sutures on the surfaces of the uterus, very much as shown in the accompanying illustration. The fixation close to the abdominal wall is, therefore, only temporary, since the adherent peritoneal surfaces stretch after the patient assumes the erect position and strain is put upon the point of adhesion by the weight of the uterus. Thus the uterus subsequently recedes to the distance of about an inch from the abdominal wall, the peritoneal band becoming a firm, fibrous cord. Consequently, instead of being fixed permanently close to the abdominal wall, as is the case after the usual ventral fixation, the uterus swings in an easy position of nearly normal ante flexion and is fairly movable.

\* Read by invitation before the Mississippi Valley Medical Association, Sept. 15, 1896.

presented by the author.



If the sutures are improperly inserted, so as to include the muscle or muscle and fascia of the abdominal wall, and are tied in the wound instead of within the peritoneal cavity, as is done by some operators, there is not the same chance for the uterus to recede, and it is held permanently very close against the abdominal wall. In some of my earlier operations the sutures were inserted in this manner, but this was very soon abandoned. In one case suppuration occurred around the knot compelling the removal of the suture, consequently the support of that suture was lost. When the sutures are inserted and tied within the peritoneal cavity, as directed by Howard Kelly, the originator of this method of suspending the uterus, they become encysted and give no trouble, provided thorough asepsis has been observed throughout the operation.

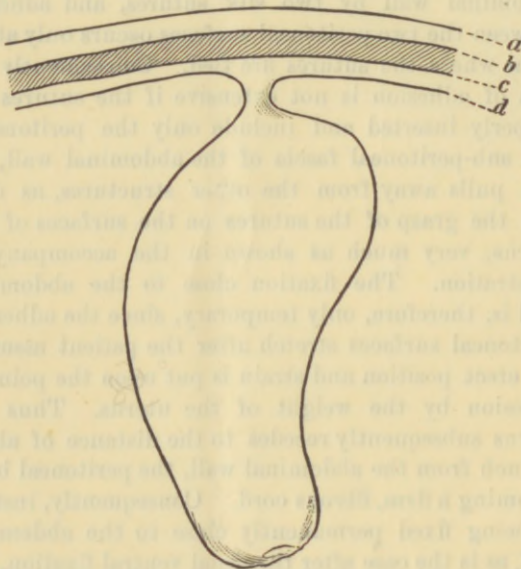


FIG. 1. *a*, skin ; *b*, muscle ; *c*, fascia ; *d*, peritoneum.

The technique of the operation is as follows: A small incision is made in the median line of the abdomen low down between the umbilicus and pubis,

opening the peritoneal cavity. The edge of the peritoneum, near the lower angle of the wound on each side, is caught with pressure forceps and drawn out. The uterus is then freed from the attachments binding it in Douglass' pouch and brought up into the wound, exposing the posterior face of the fundus. A medium-sized silk ligature is inserted by means of a curved needle upon the peritoneal surface of the abdominal wall, at the lower angle of the wound on the left side, including the peritoneum and sub-peritoneal fascia only, then it is inserted upon the posterior face of the fundus, and is brought out on the peritoneal surface of the right side of the abdominal wall at a point opposite its insertion on the left. A second suture is introduced just above the other in the abdominal wall and just below and posterior to the other on the fundus. When these sutures are tied the posterior face of the fundus is brought up close against the abdominal wall and the knots are within the peritoneal cavity. The peritoneum is united with a continuous catgut suture, closing over the suspension sutures. The abdominal wound is then closed in the usual manner.

It is not necessary to retain the uterus in a fixed position against the abdominal wall, either to overcome a retro-displacement or prolapsus, since after being maintained at or above the normal plane in the pelvis for a time the normal circulation is restored and the organ becomes lighter in weight and its walls resume a normal condition. The causes which operate to maintain the displacement being removed by lifting the organ out of its abnormal position, it resumes a normal condition. Were it possible to accomplish this by means of any artificial support in the vagina, such as a pessary, a cure could be brought about in that manner. Such a thing is possible ordinarily in movable, posterior displacements, and even in some cases of prolapsus when the organ is not too heavy and when the normal tone of the uterine supports has not been lost beyond recovery. There are cases, however, where nothing short of opening the abdo-

men and suspending the uterus in the manner described above will suffice.

The indications for ventral suspension are a retroflexed or a retroverted uterus fixed by adhesions and prolapsus. Likewise if a movable retro-deviation is complicated with a prolapsed, enlarged, sensitive ovary, suspension is preferable to Alexander's operation, since a pessary will not be required afterwards for additional support. If the prolapsed ovary is not sufficiently diseased to require removal, this is a point well worthy of consideration, as the pressure of the pessary would not be well borne.

When the displaced uterus is fixed by adhesions the advantage and greater safety of separating the adhesions through an abdominal incision, where we can have sight as well as touch to guide us and plenty of room, cannot be over-estimated. To attempt to free a badly adherent uterus through an incision in the vagina prior to the operation of shortening the round ligaments, is blind, uncertain work, and is not without a considerable element of danger. The liability of a prolapsed loop of intestine being involved in the adhesions in Douglas's pouch and the greater liability of wounding the intestine, if the attempt is made to free it through a vaginal incision, should lead us to prefer the abdominal route as the safer and more certain in these cases.

A case of this kind which came under my observation, was reported in *The American Medico-Surgical Bulletin*. A loop of intestine was so firmly adherent in Douglas's pouch, that it was impossible to detach it without wounding it, and the attempt was abandoned. If I had been working blindly through a vaginal incision instead of through the abdomen, the intestine would certainly have been wounded unavoidably before the uterus could have been detached. This condition of affairs was not suspected before the abdomen was opened, and was not discovered until the uterus and adherent appendages had been detached and lifted up.

For prolapsus, ventral suspension is an ideal operation, but any injury to the pelvic floor should be repaired either at the time or previously. Likewise, if there is an old laceration of the cervix, this should be repaired, since it will aid materially in lightening a heavy and enlarged uterus and lessen the strain upon the suspension ligaments. When the uterus is very heavy, a third suture is inserted, and the patient should be confined to bed for a week longer than in ordinary cases. Ordinarily, from two to three weeks is sufficient for the patient to be confined to bed after this operation. No vaginal support is required, but she is directed to wear an abdominal bandage for several months.

There is another indication for this operation which has not been strongly insisted upon heretofore, yet it seems to me there can be no question of its advisability. When both appendages have been removed, and if for any reason the uterus is left behind, the loss of uterine support which the broad ligaments afford should be compensated for, and how better than by suspending the uterus from the anterior abdominal wall. No doubt others have observed also, that where this is not done, these patients frequently suffer from dragging in the pelvis and more or less descent or displacement of the uterus when it has been deprived of the support furnished by the broad ligaments. It adds nothing to the risk of the operation, and the additional time necessary to suspend the uterus after removing the appendages will count as nothing. It should be done in every instance when the uterus is left.

The mortality of this operation is, practically, *nil*, considered apart from disease of the appendages which may complicate the condition for which it is done. This is one of its chief recommendations, and while it should not be undertaken too lightly in consequence of its comparative safety, and though unnecessary and therefore inadvisable in movable retrodeviations, for the conditions mentioned here it is certainly justifiable and advisable.

108 West Seventy-Third Street.



**INTERNATIONAL**  
**JOURNAL**  
**OF**  
**SURGERY**

DEVOTED TO THE THEORY AND  
PRACTICE OF MODERN SURGERY AND GYNÆCOLOGY.

Vol. IX.      January, 1896.      No. 1.

PUBLISHED MONTHLY BY  
**INTERNATIONAL JOURNAL OF SURGERY CO.,**  
106 and 108 FULTON STREET—Downing Building,  
P. O. Box 587.      NEW YORK, U. S. A.

SINGLE NUMBER 15<sup>cts</sup>, YEARLY SUBSCRIPTION \$1.00

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