

E. Debohls (Geo. M.)

WITH COMPLIMENTS OF THE AUTHOR.

**Pregnancy after Ventral Fixation
of the Uterus.**

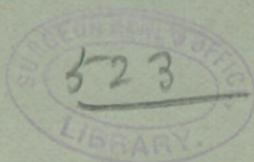
A REPORT OF FOUR CASES.

—BY—

GEORGE M. EDEBOHLS, A. M., M. D.,

GYNECOLOGIST TO ST. FRANCIS HOSPITAL, NEW YORK; PROFESSOR OF DISEASES OF
WOMEN AT THE NEW YORK POST-GRADUATE MEDICAL SCHOOL;
CONSULTING GYNECOLOGIST TO ST. JOHN'S RIVERSIDE
HOSPITAL, YONKERS, N. Y.

Reprinted from the Transactions of the New York Obstetrical Society.



PREGNANCY AFTER VENTRAL FIXATION OF THE UTERUS.

New York Obstetrical Society, November 21, 1893.

Dr. G. M. EDEBOHLS presented a patient with

A Ventrofixated Uterus Pregnant in the Seventh Month,

whose history and present condition presented points of interest.

CASE I.—M. K., aged thirty-five years, married, was sent to him by Dr. D. J. McDonald, May 16, 1892. She was the mother of three children and had one miscarriage at the seventh month, three months before coming under his observation. Following the miscarriage she bled profusely for three weeks and has since had repeated uterine hæmorrhages.

Coccygodynia, dyspnœa, and dyspeptic symptoms, such as pain after eating, bad taste in mouth, eructations, and obstinate constipation, from which she had suffered for several years past, had, since her miscarriage, all increased in severity.

On examination, the left annexa uteri were found normal; right tube normal; right ovary somewhat large. Uterus slightly large, retroverted in second degree, but easily replaceable in normal anteversion by bimanual manipulation. Cervix lacerated, hypertrophied. Perinæum lacerated in second degree; slight prolapse of anterior and posterior vaginal walls. Right kidney movable to the extent of ten centimetres in a downward direction; urine normal. Mitral regurgitation, as denoted by a loud, blowing bruit with the first sound of heart at apex.

On May 17, 1892, Dr. Edebohls performed upon her the following series of operations:

1. Curettage of uterus.
2. Amputation of the cervix uteri, after the method of Simon and Marckwald.
3. Shortening of round ligaments. The left ligament was first found and drawn out ten centimetres. The right ligament was next found and drawn out some seven centimetres, when, with-



out undue traction, it suddenly gave way within the abdomen, and he held in his hand a round ligament fifteen to sixteen centimetres long with one end free and the other attached at the pubis. Its length indicated that it had given way at its origin from the uterus. Both inguinal wounds were closed and the abdomen opened by an incision in the median line.

4. Ovariectomy. On examination of the uterus, the right round ligament was found to have been pulled out of it, a small hole denoting the site of its former insertion. The cause of the accident was found in a small *adherent* ovarian cystoma, some five centimetres in diameter, the fixation of which to the posterior pelvic wall had opposed the traction made upon the round ligament in the attempt to draw out the latter. The cyst, right ovary, and tube were tied off and removed, the healthy annexa upon the left side being allowed to remain.

5. Ventral fixation of the uterus. The retroverted uterus was brought forward and the fundus was attached to the anterior abdominal wall, in closing the latter, by three permanent buried sutures of silkworm gut. Two additional buried silkworm sutures sufficed to close the remainder of the wound. Time required for these various operative procedures, seventy minutes.

An acute catarrhal pneumonia, beginning on the third and ending on the tenth day after operation, and which involved the greater part of the right lung, complicated convalescence. The three abdominal wounds and the cervix all healed by first intention and the patient left hospital exactly four weeks after operation.

The symptoms due to the movable right kidney, and the coccygodynia, however, persisted and the patient re-entered hospital in November, 1892.

On November 18, 1892, Dr. Edebohls performed upon her—

6. Nephrorrhaphy for fixation of the right kidney, and—

7. Perineorrhaphy, after the method described by him in the *American Journal of Obstetrics*, October, 1890, both operations being performed at the same sitting.

Both wounds again healed by primary union, and the patient left hospital four weeks later. Since then she has suffered only from the dyspnoea due to the cardiac lesion and from coccygodynia.

In June, 1893, patient again came to him for the purpose of having her coccyx removed, which he had promised to do for her, if other treatment of the coccygodynia proved of no avail. The fact, however, that the patient, who had always been very regular,

had gone a week beyond a due period, and other symptoms, led him to suspect pregnancy and to postpone active measures.

His suspicion proved well founded and the patient is now in the seventh month of pregnancy, her last menstruation having occurred May 16, 1893. The course of this pregnancy thus far has been smoother than that of her four previous ones, absolutely no symptoms having occurred to disturb her, and the foetal movements are very active.

On examination, the right kidney is found securely anchored at the site of the lumbar scar. The remnant of the cervix is very high in the vagina. The uterus is enlarged to a size corresponding to the seventh month of pregnancy.

The only abnormality about the uterus is a decided thickening of the portion attached to the anterior abdominal wall by the three buried silkworm sutures. This, together with a decided tilting forward of the fundus and a corresponding undue dilation of the posterior segment, correspond to observations made in similar cases, under like circumstances, by other observers.

He was inclined to believe that the unusually marked thickening of the uterine wall, at the site of its attachments to the abdominal wall, had something to do with the fact that the fundus was secured by three buried silkworm sutures, quite a large uterine surface being thus attached. He considered one such buried suture, properly applied, quite sufficient to insure permanent anteversion of the uterus; and would in future, in performing ventrofixation of the uterus, when the possibility of a future pregnancy was not excluded, limit himself to one suture for attaching the fundus. In case of a subsequent pregnancy, he would then expect a uterine development more nearly approximating the normal than in the patient exhibited this evening.

The first point of interest, then, in connection with the case, was the fact that such an unusual number of operations had been performed, all with the happiest results, upon a patient suffering with organic lesion of the heart.

A second point, the tearing of the round ligaments out of the uterus, he would refer to again after the presentation of his second patient, in whom the same accident occurred.

A third, though perhaps minor, point of interest centered upon the occurrence and smooth progress of pregnancy in a uterus whose cervix was all but entirely removed by amputation, whose fundus was ventrofixated, and whose right tube and ovary had been ablated.

He would respectfully request the president to appoint three or four of the Fellows, who might be interested, to examine the patient

and to report upon her condition, especially that of the uterus.

Dr. A. H. BUCKMASTER, one of those asked to examine this patient, reported that the uterus was more or less fixed, and there was evidence of considerable thickening in the anterior wall. The operation scar was quite small, and the patient seemed to be in good condition.

Dr. PRYOR said he had also examined the patient. He had inquired of the patient as to her symptoms, and there seemed to be none which could be traced to the operation. He thought the abdominal scar was adherent to the uterus, but Dr. Edebohls had assured him that the uterus was fixed from the very top of the fundus to the abdominal parietes. From the fact that pregnancy had progressed so far without interruption, he would imagine that the sutures had torn out. Certainly, the patient's condition was excellent. There had been a very small incision, there was no appearance of ventral hernia, the sutures could be felt buried under the skin, and he thought probably there was a band of adhesion running from the scar in the abdomen to the old site of the sutures in the fundus.

Final Report, made to the Society April 17, 1894.

Dr. G. M. EDEBOHLS made a final report upon the case of the patient M. K., whom he had presented to the Society at the meeting of November 21st, 1893. The patient was, at the time, pregnant in the seventh month, and he had promised to present her again after her delivery. This, unfortunately, he was unable to do for the reason that she was no longer among the living.

He saw her for the last time on Feb. 20, 1894, when she was quite well and hourly expecting her confinement. On Feb. 23, she suddenly dropped dead while engaged in her household duties. The cause of death was an organic cardiac lesion, insufficiency of the mitral valve. Her family physician, Dr. D. J. McDonald, could not reach her until two hours after her death, too late for a post mortem Cæsarean section.

Dr. G. M. EDEBOHLS next related the history of a

Case of Ventrofixation of the Uterus now Pregnant at Term.

He had hoped to be able to show the patient to the society this evening, but she expected her confinement momentarily and was afraid to leave her home.

CASE II.—A. B., a married woman of twenty-five years, mother of two children, came under his care January 2, 1893.

Her symptoms dated from her last confinement, in August, 1891, and though varied, presented no point of special interest.

Examination showed normal appendages; uterus normal in size, retroverted in second degree; cervix slightly lacerated, soft; a large cystocele; laceration of perinæum in second degree.

On January 3, 1893, Dr. Edebohls performed upon her the following series of operations:

1. *Curettagé of Uterus*.—The sharp curette, on its first introduction, passed without appreciable resistance through the soft posterior wall of the corpus uteri and entered the free peritoneal cavity. The accident was at once recognized and the curette gently withdrawn. Confident of his asepsis and conscious that no injury had been done by the instrument within the peritoneal cavity, he finished the curettagé, treating the perforated posterior wall of the uterus with special gentleness and consideration, and proceeded to do—

2. *Anterior Colporrhaphy*.—Elliptical denudation. Closure by the buried running catgut suture.

3. *Colpo-perineorrhaphy*, after the same method as in the previous case.

4. *Shortening of Round Ligaments*.—Left ligament first found and drawn out. Right ligament found, drawn out, and pulled out of uterus without undue traction. He immediately opened the abdomen and performed—

5. *Ventral fixation of the Uterus*, the fundus being attached to the anterior abdominal wall by two buried sutures of silkworm gut.

Uneventful convalescence. Primary union of all wounds. Left hospital four weeks after operation.

Pregnancy occurred almost immediately, the patient menstruating but once after operation, on March 2, 1893.

He did not see her again until she was exactly four months advanced in pregnancy. He then found the same condition of the uterus, though less marked, which existed in the first patient, the uterine wall being thickened at the site of its attachment to the abdominal wall, and the enlargement of the womb being mainly at the expense of the posterior wall.

He visited her yesterday and found that the pregnancy had gone on undisturbed to near the end of the ninth month. She was considerably larger than with her former children, and had suffered proportionately from more pronounced pressure symptoms. Fœtal movements were very active, and the uterus was symmetrically distended, reaching to ten centimetres above the umbilicus.

There was no thickening or tenderness of the uterus behind the cicatrix of the abdominal wound or elsewhere. He would endeavor to keep track of both patients, and hoped to be able to present both of them to the society after delivery.

He would not expatiate upon the perforation of the uterine wall with the curette further than to say that both the fact and the site of perforation were demonstrated at the cœliotomy for ventrofixation of the uterus, and that the ease of perforation, as well as the facility with which the round ligament was pulled out of the uterus, were explained by the far-advanced state of fatty degeneration in which he found the latter organ. As in the former case, he found a hole in the right cornu of the uterus to mark the site of origin of the departed round ligament. He regretted that in both this and the previous case, he did not pass the round ligament back into the abdominal cavity through the internal ring and unite it by suture to the uterus to the point where it had been torn out. Should a similar accident again occur to him, he would adopt this procedure.

Altogether the accident of drawing the round ligament out of the uterus had occurred to him with three of the one hundred and thirty-six round ligaments (sixty-eight cases) which he had shortened. Twice it was due to advanced fatty degeneration of both round ligaments and uterus. In the third case, that of the patient presented this evening, an error in diagnosis—failure to recognize posterior fixation of a cystic ovary—was responsible for the accident. In each of the three cases the inguinal wounds were immediately closed, the abdomen was opened in the median line, and the fundus uteri attached by suture to the anterior abdominal wall.

Subsequent history.—The patient was delivered of a full grown girl on Dec. 11, 1893. Vertex presentation; spontaneous delivery; labor lasting twelve hours; no complication or anything unusual.

On Feb. 20, 1894, she was again presented to the society and examined by Drs. Janvrin, Goffe, Waldo and Edebohls. They found the uterus in anteversion, high up in pelvis, fundus attached to anterior abdominal wall. Cervix in fair condition. Perineum lacerated in second degree. The ventral fixation had therefore stood the test of a subsequent pregnancy and confinement at term.

New York Obstetrical Society, April 17, 1894.

Dr. EDEBOHLS presented a patient seven months pregnant, whose history read as follows:

CASE III.—E. G., married, 25, mother of one child, was sent to him in March, 1893, by her family physician, Dr. P. J. Lynch. Examination disclosed a slightly enlarged retroverted uterus, normal sized but adherent appendages, a cervix lacerated in several directions, two cicatricial ridges in vaginal vault and a perineum lacerated down to the sphincter ani.

On March 28, 1893, he performed at one sitting :

1. Curettage of uterus.
2. Trachelorrhaphy.
3. Perineorrhaphy.
4. Ventral fixation of the uterus, the fundus being attached to the anterior abdominal wall by three buried silk-worm sutures.

Time for all operations seventy minutes.

The patient made a good recovery and was discharged April 19, 1893. A month later one of the buried sutures gave trouble and was removed.

The patient is now seven months pregnant. She has thus far not felt any difference as compared with the corresponding months of her first pregnancy. The abdominal cicatrix is firm and the fundus uteri is securely fastened to its posterior aspect. The same ballooning of the posterior wall of the uterus can be felt which existed in the patient he had presented on November 21, 1893. He would endeavor to present her again three or four months after delivery.

Drs. Janvrin and Marx were asked to examine the patient and report upon her condition.

Dr. Janvrin reported that the fundus of the uterus was still firmly attached to the upper end of the abdominal incision and the posterior wall of the uterus seemed to have become greatly distended.

Dr. S. Marx said that the fundus still remained in position, and yet above this the uterus was remarkably "ballooned," as if the enlargement were more posteriorly and to both sides, at the expense of the anterior portion. She had stated to him that she never suffered from pain since becoming pregnant.

Subsequent history.—On July 8, 1894, patient was delivered of a large male child by Dr. Peter Hughes of Brooklyn, N. Y. Labor began at 1 P. M. and was terminated by forceps at 10.45 P. M. Perineum torn, requiring five sutures, which were applied by Dr. Hughes.

On August 4, perineum was found well united. Uterus of proper size for period of time following labor, in normal anteversion and at normal height in pelvis. Fundus securely attached to anterior abdominal wall. Abdominal cicatrix firm.

Dr. Edebohls presented for examination a second patient, whose present condition after a

Pregnancy following Combined Operations for Complete Prolapsus Uteri et Vaginæ

had interested him considerably.

The previous history of the patient he had already outlined as CASE VI., in a paper on "The Operative Treatment of Complete Prolapsus Uteri et Vaginæ" (*American Journal of Obstetrics*, Vol. XXVIII., No. 1, 1893).

CASE IV.—M. M., aged 35, married, mother of two children, came to him in November, 1891. Following the birth of her first child, two years previously, she had partial prolapsus; since the birth of her second child, six months ago, there was complete prolapsus uteri et vaginæ, both of these organs lying entirely outside of vulva. Cervix deeply lacerated and hypertrophied. Ovaries and tubes normal in size.

On November 11, 1891, he performed upon her at one sitting, and in the order named: amputation of cervix, anterior colporrhaphy, ventral fixation of uterus and colpo-perineorrhaphy. The uterus was attached to the anterior abdominal wall by three silkworm-gut sutures which were removed on the eighth day. All operative wounds healed by primary union, and the patient was discharged on Dec. 10, 1891.

She remained cured of the prolapsus, became pregnant and gave birth to a child at term on February 24, 1893. Dr. E. de Motte Lyon, of Peekskill, N. Y., who attended her in confinement, kindly wrote him that nothing unusual occurred during labor. Child fully developed at birth and still living.

Her condition to-night, fourteen months after delivery, is as follows:

Uterus of normal size, anteverted, well up in pelvis, with fundus firmly attached to coeliotomy cicatrix. Cervix slightly nicked. Vagina somewhat redundant. Laceration of perineum in first degree, with very slight eversion of posterior vaginal wall.

The case represents an operative cure of complete prolapsus uteri et vaginæ, lasting two and a half years, and having successfully withstood the ordeal and crucial test of a subsequent gestation and labor at term.

Dr. Janvrin examined the patient and reported that he found the uterus to be in exactly the same position that it occupied immediately after the operation, *i. e.*, it was firmly adherent to the abdominal wall.

