

Edebohls (G.M.)

COMPLIMENTS OF THE AUTHOR.

THE OPERATIVE TREATMENT OF COMPLETE  
PROLAPSUS UTERI ET VAGINÆ.<sup>1</sup>

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

Professor of Diseases of Women at the New York Post Graduate Medical School and Hospital;  
Gynecologist to St. Francis' Hospital, New York.

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ONE purpose of this communication is to call renewed attention to, and to emphasize, the fact that prolapsus of the uterus, even in its severest forms, is readily, speedily, and permanently curable by modern gynecic surgery.

My second object is to elicit, in the discussion to follow, your individual experiences and methods in the operative treatment of complete prolapse of the uterus and vagina. For although we may all agree that prolapsus is curable by operation, yet will we probably differ considerably both in the kind and in the technique of the operations we employ.

Personally I am not wedded to any routine line of operative treatment, but am inclined to be eclectic, and try to differentiate the indications as presented in individual cases as far as I am able. And this notwithstanding a satisfactory degree of success in the employment of ventrofixation of the uterus combined with the various plastic operations called for by the condition of the uterus, vagina, and pelvic floor, all required operations being performed at one sitting.

I have limited myself in this paper to *complete* prolapsus of the uterus and vagina—*i.e.*, to the consideration of those cases only in which the entire uterus and vagina are outside of the vulva. It will be readily granted that, provided we can deal successfully with these extreme cases, the lesser degrees of prolapsus should offer no special difficulties.

<sup>1</sup> Read before the annual meeting of the American Gynecological Society 1893.



The first question that arises in connection with the operative treatment of complete prolapsus of the uterus is one of principle: Shall we endeavor to preserve the uterus, or shall we remove the prolapsed organ by total extirpation? Until such time as it can be shown that the results achieved by total extirpation of the uterus for prolapsus are better and more lasting, as well as that the operation is no more dangerous than the rival procedure, I shall adhere to ventrofixation of the uterus combined with the necessary plastic operations as the rule, practising total extirpation only on exceptional indications.

Such exceptional indications, to my mind, are :

1. A uterus so large and heavy that it cannot be reduced to an approximately normal size and weight by amputation of the cervix.
2. A uterus presenting either positive evidence or strong suspicion of malignant disease.
3. A uterus with appendages so diseased that the condition of ovaries and tubes calls for their removal, apart from other considerations.

It must be remembered, also, that total extirpation of the uterus is in itself not sufficient to cure complete prolapsus of the uterus and vagina, but that plastic operations, of one kind or another, upon the vagina and the pelvic floor are required in addition.

The only method of total extirpation for prolapsus claiming to dispense with the necessity, in some cases at least, of these added plastic procedures, is that advocated and practised by Dr. W. M. Polk. Dr. Polk opens the abdomen, removes the uterus from above, and attaches the cut end of the vagina to the abdominal wall in closing the wound of the latter. The ingenuity, originality, and plausibility of the procedure recommend it strongly, even without the crucial test of its successful use by such a reliable observer as Polk. Although I have no reason to be dissatisfied with my experience, limited though it be, in the combination of vaginal hysterectomy with operations upon vagina and perineum, I shall, in the next case of total prolapse calling, in my opinion, for total extirpation of the uterus, give the method of Polk a trial.

My objections, then, to the routine practice of total extirpation of the uterus for prolapsus of that organ and the vagina are based on two grounds mainly. Firstly, because the practice is opposed to that rule of conservative surgery which calls for the

preservation of all organs which by their presence menace neither life nor health. Secondly, because total extirpation neither lessens the danger nor simplifies the operative technique, except, perhaps, when practised after the method of Polk.

On the other hand, with healthy tubes and ovaries, ventrofixation of the uterus, combined with plastic operations, preserves the possibility of child-bearing, and for that reason alone is entitled to favorable consideration in quite a large number of women.

Leaving out of consideration now those exceptional instances in which total extirpation is called for in the treatment of complete prolapsus of the uterus and vagina, I would strongly insist, in all cases of complete prolapsus, in the operative treatment of which the uterus is preserved, upon ventrofixation of the uterus as an essential adjunct to whatever plastic operations upon the uterus, vagina, and perineum may seem called for.

A properly performed ventrofixation of the uterus gives a better guarantee of permanent cure of the prolapsus than any one of the additional plastic operations singly, or perhaps than any given combination of these additional operations looking to the preservation of a vagina, can give. And this preservation of a vagina is a very important matter to nearly every one of our patients.

Consequently I would lay it down as an axiom that whenever the uterus is preserved in prolapsus operations it should be *securely* ventrofixated. I say securely advisedly, because in the only one of my cases of uncomplicated complete prolapsus in which I did ventrofixation, and in which I have known a recurrence of the prolapse to take place (Case 4), I have reason to believe that the uterus was not properly ventrofixated, the transperitoneal hysterorrhaphy of Krug having been performed. By this I do not mean to assert that the failure was due to the method of operation. The fault may have been with the operator, whose first as well as last experience with the method it constituted.

I confess to a considerable degree of scepticism regarding the ability to obtain a permanent cure of *complete* prolapsus of the uterus and vagina by the various methods of vaginal fixation of the uterus after Schücking, Dührssen, Mackenrodt, and others, although a number of operators seem to be satisfied with their results thus obtained.

Whatever plastic operations, joined with ventrofixation of the uterus, are indicated by the conditions presented in a given case of prolapsus of the uterus and vagina, I cannot too strongly insist,

No.	Name.	Age.	State.	Children.	Condition before operation.	Date of operation.	Operations performed.	Result.
1	K. W.	43	Married.	2	Tubes and ovaries normal. Complete prolapsus of uterus and vagina. Laceration and great hypertrophy of cervix.	February 19th, 1890.	Amputation of cervix. Shortening of round ligaments. Perineorrhaphy.	April 19th, 1893: Uterus at normal height in pelvis and in normal anteversion. Vagina and perineum normal. Slight cystocele. Has been doing the hardest of housework and considers herself perfectly well. Result perfect six weeks after operation. No trace of patient since.
2	M. P.	44	Married	8	Ovaries and tubes normal. Complete prolapsus of uterus and vagina. Laceration and enormous hypertrophy of cervix. Uterine cavity 11.5 centimetres deep.	March 5th, 1890	Amputation of cervix. Shortening of round ligaments. Perineorrhaphy.	Result good on discharge, a month after operation, since when patient has not been seen or heard from.
3	K. S.	54	Widow.	4	Ovaries and tubes normal in size. Complete prolapsus of uterus and vagina. Uterine cavity 13 centimetres deep. Corvix deeply lacerated and enormously hypertrophied. Extensive ulcerations of vagina.	June 2d, 1890.	Amputation of cervix. Anterior colporrhaphy. Colpo-perineorrhaphy.	Complete failure, the prolapsus recurring in two months. Prolapsed uterus impregnated; abortus produced by family physician at third month. Second operation two years later (Case 10).
4	L. M.	35	Married,	2	Ovaries and tubes normal in size. Complete prolapsus of uterus and vagina. Uterine cavity 9.5 centimetres deep. Cervix lacerated and deeply excoriated.	December 3d, 1890.	Anterior colporrhaphy (purse string operation). Hysterorrhaphy (transperitoneal method of Krug). Colpo-perineorrhaphy.	Remains well although doing the hard work of a restaurant cook. Uterus well up, firmly attached to anterior abdominal wall. Perineum and posterior vaginal wall normal. Slight cystocele. Last seen April 19th, 1893.
5	E. F.	33	Widow.	2	Extensive diastasis of recti abdominis. Ovaries and tubes normal in size. Complete prolapsus of uterus and vagina. Cervix lacerated and moderately thickened.	April 1st, 1891.	Curettage of uterus. Amputation of cervix. Anterior colporrhaphy (purse string operation). Ventrofixation of uterus. Perineorrhaphy.	

6	M. M. 35	Married.	2	Ovaries and tubes normal in size. Complete prolapsus of uterus and vagina. Deep laceration and hypertrophy of cervix.	September 11th, 1891.	Amputation of cervix. Anterior colporrhaphy. Ventrofixation of uterus. Colpo-perineorrhaphy.	On discharge, a month later, uterus well up in pelvis, firmly attached to abdominal wall. Vagina and perineum normal. Patient lost sight of. Miscarried at second month, in October, 1892. Seen April 17th, 1893. Uterus, vagina, and perineum remain as they were immediately after operation. Complete cure.
7	M. M. 36	Married	5	Complete prolapsus of uterus and vagina. Bilateral laceration and thickening of cervix.	March 11th, 1892.	Curettage of uterus. Amputation of cervix. Anterior colporrhaphy. Perineorrhaphy. Ventrofixation of uterus.	Perfect result, the patient remaining cured when last seen, more than a year after operation.
8	C. L. 51	Married.	6	Ovaries and tubes normal in size. Complete prolapsus uteri et vaginæ of twenty-seven years' standing. Unsuccessful operations, in competent hands, three years ago.	April 1st, 1892.	Curettage of uterus. Anterior colporrhaphy. Colpo-perineorrhaphy. Ventrofixation of uterus.	Perfect result, the patient remaining cured when last seen, more than a year after operation.
9	M. K. 28	Single.	..	Ovaries and tubes normal. Complete prolapsus uteri et vaginæ, the result of a severe strain at lifting three years ago. Uterus has never been replaced since	May 6th, 1892.	Curettage of uterus. Lateral colporrhaphy. Perineorrhaphy. Ventrofixation of uterus.	Patient remains absolutely cured, a year after operation, although having done the hardest work ever since
10	L. M. 37	Married.	2	Case 4. relapsed, the same conditions presenting as recorded in Case No. 4.	October 4th, 1892.	Curettage of uterus. Lateral colporrhaphy. Bilateral salpingo-oöphorectomy. Ventrofixation of uterus.	Perfect result, lasting to date, May 13th, 1893.
11	R. W. 45	Married.	10	Ovaries and tubes normal in size. Complete prolapsus of uterus and vagina. Laceration of cervix.	December 20th, 1892.	Curettage of uterus. Amputation of cervix. Anterior colporrhaphy. Colpo-perineorrhaphy. Ventrofixation of uterus.	Perfect result, with exception of slight cystocele, when last seen, April 15th, 1893.
12	M. C. 61	Married.	1	Ovaries and tubes normal in size. Complete prolapsus of uterus and vagina. Complete inversion of cervix uteri	January 27th, 1893.	Vaginal hysterectomy, both tubes and ovaries being removed with the uterus. Lateral colporrhaphy. Perineorrhaphy.	Perfect result, lasting to date, May, 1893.

upon the performance of all of them, including the ventrofixation, at one sitting. Not only is our patient at this day entitled to expect this from the expert and to claim only one anesthesia, but the result must be better when all operations are performed at one sitting, each separate operation forming one stone of the arch, the integrity of which is endangered by even the temporary absence of one such stone.

The various combinations of operations I have practised in each of my twelve cases, comprising my entire experience, exclusive of two cases already published, with the operative treatment of *complete* prolapsus uteri, will be found recorded in the table appended. The two cases already reported were complete failures. In one <sup>1</sup> the prolapsus was due to a tubercular ascites. In the other <sup>2</sup> ventrofixation of the uterus was not performed.

As I have, in the second of the papers just alluded to, fully described my technique in the performance of the various operations entering into combination in the treatment of complete prolapsus uteri, I will not enter anew upon the subject here.

I will merely reiterate that I have abandoned shortening of the round ligaments, as a prolapsus operation, for the reason that, although a good and permanent result was obtained in Case 1 of the appended table, it has signally failed to realize expectations in a number of cases of incomplete prolapsus in which I have employed it in conjunction with plastic operations.

A phenomenon of quite frequent occurrence, in cases otherwise showing perfect results, has been the recurrence of a slight cystocele, not annoying to the patient, but still indicating to the operator a desideratum in the shape of improved technique with a view to its prevention.

In the three cases in which lateral colporrhaphy was performed instead of an anterior and a posterior colporrhaphy, no cystocele was subsequently noted. The writer believes that this result is not merely dependent upon chance, but is associated with the fact that in performing lateral colporrhaphy we secure a hold upon the fixed lateral walls of the pelvis, whereas in anterior and posterior colporrhaphy we attach the vagina to movable organs,

<sup>1</sup> "Tubal and Peritoneal Tuberculosis," Transactions of the American Gynecological Society, 1891.

<sup>2</sup> "Combined Gynecological Operations," American Journal of the Medical Sciences, September, 1892.

the bladder and rectum. Re-descent of the vagina, dragging with it the bladder and establishing a cystocele, is thus favored.

Another great advantage of lateral colporrhaphy lies in the mathematical precision with which we are enabled to give any desired size to the resultant vagina. By leaving, for instance, a longitudinal strip, three centimetres in width, in connection with the bladder, and another of equal size attached to the rectum, removing the entire lateral walls of the vagina between these strips and approximating the lateral margins of the strips by sutures, a vagina six centimetres in circumference and about two centimetres in diameter will be left.

All the operations recorded for each case of the accompanying table were invariably performed at one sitting. Primary union was obtained in every plastic operation, and in all the ventrofixations except two. In these a small mural abscess for a short time delayed complete recovery.

