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CONTENTS.

ORIGINAL COMMUNICATIONS:
Hysteroscopy, E. Farrell, M. D. ........................................ 323
Antipyretics, F. W. Goodwin, M. D. .................................... 326

CORRESPONDENCE:
American Hospitals, John Black, M. D. .............................. 328
London Letter, J. Stewart, M. D. ......................................... 329
St. John Medical Society ..................................................... 332

EDITORIALS:
The Profession and the State ............................................... 333
P. E. Island Hospitals ....................................................... 334

Fallerton Inquest ............................................................ 334
Canadian Medical Association .............................................. 337
Evidence Fullerton Inquest ............................................... 339

BOOK REVIEW:
International System of Electro-Therapeutics, Bigelow .......... 342

BOOKS AND PAMPHLETS RECEIVED ..................................... 343

SELECTIONS:
A method of assuaging Thirst in Diabetes &c. ....................... 344

Original Communications.

HYSTERORRHAPHY, OR VENTRAL FIXATION OF THE UTERUS WITH FOUR SUCCESSFUL CASES.

By E. Farrell, M. D.

Hysteroscopy is one of the latest developments in surgical gynecology. It is an operation for the cure of malpositions of the uterus, more particularly retro-positions and prolapse. The operation may be said to be a serious one, as it involves abdominal section, but is simple, in most cases easily done, and should be devoid of all danger if the most strict asepsis is observed.

The operation is first an incision through the abdominal wall in the median line above the pubis (the bladder and rectum being empty). Gently and carefully the uterus and ovaries are explored, and the uterus lifted from its false position; if adhesions exist they are gently broken down by the fingers, and the organ is brought up against the abdominal wall. This is not as easy as one would suppose; the working in between the fingers of loops of intestine is sometimes very troublesome. Since the use of the Trendelenburg position this difficulty is to a great extent avoided. This position, which is obtained simply by elevating the foot of the operating table to about an angle of 45°, the patient’s hips being elevated and the head and shoulders depressed, the abdominal contents are thrown back upon the diaphragm, and the pelvic cavity is emptied of all but its normal contents. It is extraordinary to what an extent this position facilitates this as well as other operations within the pelvis. One can hardly describe the advantages of this position. It is necessary to have had experience of it as an operator to fully appreciate the ease and safety it affords. When the uterus is grasped it is not always easy to hold it in position during the operation; in my last two operations immediately on bringing the uterus up in the wound, I have used a sharp hook
or small vulsella forceps, catching the uterus near the fundus, about midway between the two points at which the sutures are to be inserted. This enables the operator to have both hands free, an assistant holding up the uterus; it also makes a point of irritation in the uterine serosa where it is expected the organ will adhere to the parietal peritoneum. When the uterus is brought up it and the appendages are examined, and the next step consists in fastening the uterus to the abdominal wall. This is not difficult. It is done by passing two of the lower sutures, by which the wound in the wall of the abdomen is closed, through the uterus, that is, each one is first passed through the whole thickness of the abdominal wall on one side, then passing the needle through the substance of the uterus just beneath the serous membrane and near the fundus, then passing it through the opposite abdominal wall. There may be a little oozing from the stitch-holes in the uterus, but this soon ceases. Now the space between the stitches on the surface of the uterus is gently scraped with the scalpel, and a small part of the parietal peritoneum is dealt with in the same way. The wound is now closed in the ordinary way and dressed. About the tenth or twelfth day the stitches are removed.

In all the cases I submit, except one, medium sized silk was used exclusively, and the plan detailed above was followed. In one case I first sutured the uterus to the peritoneum alone with cat-gut, and used silk for complete closure of the wound.

The following histories were kindly furnished me by Dr. Finn, of the Halifax Dispensary, and Dr. Arbuckle, of the Victoria General Hospital:

Case I.—A. L., age 29 years, unmarried, came to Hospital suffering from retroversion of uterus, a condition which made her an invalid for the last 3 years. Her symptoms at this time were pain in the back, sensations of weight in the pelvis, and constipation. She had been under treatment during illness but her condition was not improved. It was decided to do an abdominal fixation. The incision being made it was found that the uterus was retroposed, no adhesions, two cat-gut ligature sutures were used to unite the fundus and the parietal peritoneum, these were cut off and buried, and by them the uterus was fixed to the abdominal wall. The incision was closed by six silk sutures and the wound dressed. The temperature after the operation did not rise above a 100°. On the ninth day the wound was dressed and the stitches removed. No suppuration; five days afterwards the temperature began to rise and the wound was again dressed. At the lower part of the incision a small abscess, containing about half-an-ounce of pus, had formed, the pocket extending inwards 2½ inches. The temperature did not fall as was expected, and the wound was dressed every day for ten days, when it was found that the cat-gut had been the cause of the suppuration and had sloughed away. The temperature then fell and the patient made an uninterrupted recovery. At the end of six weeks she was able to get up, and four weeks later left the hospital. The pain in back, constipation, and sensation of weight in pelvis had disappeared.

Case II.—H. B., age 68 years, married, came to hospital, suffering from prolapse of uterus, secondary to birth of first child, 45 years ago. During the last seven years was an invalid, as it was impossible to keep the uterus in place by supports, as it went constantly outside the vulva. Abdominal fixation was performed. The operation differed from the above in that the two lower silk sutures used to close the abdominal incision were also carried through the upper anterior aspect of the fundus. The surface of the fundus, in opposition to the abdominal wall, was scraped so as to ensure...
July, 1894.

MARITIME MEDICAL NEWS.

325

better adhesion. Three other silk sutures were used to close the incision and the wound dressed. Temperature after operation never rose above 100°. The eighth day wound was dressed and stitches removed,—no suppuration; a week later the wound was again dressed and everything found to be healed. At the end of three weeks patient was able to sit up, and in two months was able to go around. By vaginal examination cervix could hardly be felt, but there was still some cystocele and rectocele. Six weeks later posterior colporrhaphy was performed, after recovery from which the patient went about with comfort, wearing a pad.

Case III.—L. McK., age 13 years, unmarried, was sent to hospital, suffering from retroversion of uterus without adhesions. Symptoms, pain in back and depressed nervous condition. Her trouble began 25 years ago, and she has been an invalid for the last two years. Pessaries failing to produce the desired effect, abdominal fixation was performed. The method was similar to case II, with the exception that the fundus was not roughened to produce adhesions. The uterus was found to be enlarged and congested. The ovaries being the seat of cystic degeneration were removed. Temperature did not rise above a hundred (100°) degrees. Wound dressed on the ninth day and stitches removed. Three days afterwards the bandages were removed and the wound was found to be completely healed. Patient was able to get up at the end of six weeks, and left the hospital three weeks later improved. Before leaving the hospital the patient was examined and the uterus found to be in normal position. The pain in the back was lessened, the weight in the pelvis gone, and the marked nervous symptoms diminished. A point worthy of note in this case was that after the removal of both ovaries the patient menstruated for a time.

Case IV.—Mrs. A. D., aged 51, married. Admitted May 9th, 1894, to Halifax Infirmary. Family history is good. She has been married twenty-nine years. Has had five children, one dead. Never had any miscarriages. After birth of fourth child, twenty-one years ago, began to feel ill; she ascribes this illness to a sudden jar received by falling off a lounge—her womb was displaced. Had Alexander's operation performed at St. Margaret's Hospital, Boston, Mass., four years ago. Had very good results for three years after; then she over-taxed herself and thinks the old complaint has returned.

By examination found a great laxity of the abdominal wall, and by bi-annual examination the uterus was felt to be thrown to the left side and posteriorly, retroversion being more marked than retroflexion; ovaries found to be small. Vagina was very much relaxed. On introducing sound into uterine cavity found it to bleed a little on touch.

On May 11th, '94, hysteroscopy was performed. The bowels were moved the previous day, and the patient given a warm bath. Abdominal wall was rendered surgically clean and opened under strict antisepic precautions. The uterus was found resting posteriorly on the rectum, it was brought to the opening in abdominal wall and held there by a small vulsella. Two strong sutures of silk were then passed through the abdominal wall and through the anterior aspect of the uterus. The anterior surface of the uterus was vivified by scraping it with scalpel. Silk sutures were then introduced into abdominal wall to close wound. All sutures were drawn tight and tied off. The ordinary aseptic dressings were applied and patient put to bed. The after result was very satisfactory, no abnormal temperature or pulse at any time. On May 23rd the sutures were removed, and on 25th she got up for a little while, moved about. Went home about June 6th, 1894.