With the Author's Compliments

TREATMENT

OF

DYSMENORRHŒA AND STERILITY

RESULTING FROM

ANTEFLEXION OF THE UTERUS.

BY

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On the Treatment of Dysmenorrhœa and Sterility resulting from Anteflexion of the Uterus. By Thomas Addis Emmet, M.D., Surgeon to the State Woman's Hospital, New York.

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Experience demonstrates that the normal position of the uterus is a part of the individuality of each female. With the unmarried, the organ is frequently found in health with some deviation toward the pubes from the ideal point accepted by the profession as its natural position, yet unappreciated, unless some inflammatory condition be added.

Anteflexions are to be regarded as resulting from a malformation of the neck, or from some obstruction in the circulation of the organ. Dysmenorrhœa, so far as it depends on the uterine condition under consideration, is the result of an encroachment on the canal, of inflammation, or atrophy of the body.

In the same connection, sterility is a sequence of obstruction and its progressive results.

A long, narrow and pointed, or snout-shaped condition of the cervix is to be regarded as a deformity. At an early period of life the balance is lost between the relative growth of the body and the neck. With the body acting as a lever, the neck, yielding to pressure, gradually becomes flexed in conformity to the curve of the posterior wall of the vagina, while it has a tendency to be pressed forward toward the outlet, from the weight of the viscera above. From the first menstrual

period, with an obstruction existing, the organ is not relieved; in fact, a chordee condition results from the obstructed state of the circulation on the side of the flexure, at each menstrual period, while the circulation is unimpaired on the opposite side.

Just previous to and during the catamenia, a flexure always becomes greatly increased, and continues for several days after the flow has ceased, before an approximation to the original condition is reached, just in proportion to the readiness with which the organ has been able to relieve itself. By a gradual process, chronic, congestive hypertrophy of the body is brought about, or else, by the sudden arrest of the menstrual flow, from cold, or any other accidental cause, an inflammatory condition becomes superadded, and either condition, by its undue weight, mechanically increases the version.

Although the flow is usually scanty at first, in many cases it becomes for a time more than natural, lasting often from six to eight days. During a series of years, however, the period becomes gradually shortened to a few hours in duration, and to a mere show in quantity. Finally, nature desists from her fruitless efforts, and a permanent change of life takes place at an earlier period than is natural.

The usual age is about thirty, although I have seen it occur at twenty-five, and in a few cases the time was extended to thirty-five or forty, always bearing an exact ratio to the degree of flexure. A previous deposit of miliary tubercles having taken place at this period, they rapidly soften, and in a large number of cases the mistake of cause and effect is often made by the profession.

Every physician who has turned his attention to uterine disease can recall a variety of cases, presenting each phase of

progression. A limited number pass the ordeal, and enjoy good health in after life, but how many fall by the wayside? As a result of my experience, I am positive that it is the most frequent cause known of phthisis in the young, as well as of sterility, a cause of unhappiness to the married female.

Long before nature desists from her efforts, atrophy of the organs takes place, with fatty degeneration at the seat of flexure. An absorption of tissue in the anterior wall of the uterus at the point in question has been brought about by pressure, and the relative position of the body and neck becomes permanent. As in the breaking down of the spongy portion of the spinal column, the mechanical result is the same, the curvature being in proportion to the loss of structure. So frequently is an obstruction of the canal a cause of sterility, that it may be accepted as the rule, and all the other known causes as the exception.

Occasionally, where the flexure is slight, and confined to the neck, a fortunate pregnancy takes place, but, as a rule, marriage aggravates every symptom, for, in obedience to nature's law, a shattered nervous system is the tribute exacted of every childless female in the marriage state. Fortunately, the progressive stages are gradual, and can be relieved, if attempted before the reparative powers have been destroyed.

Our attention must be directed to relieving the dysmenorrhœa, and to removing the cause of sterility, for pregnancy will bring about a more radical change in repairing the injury done, than can be accomplished by art. All remedies applicable are but palliatives, and cannot remove a mechanical cause. Dilatation is unphilosophical, and can only succeed when the flexure is so slight that local treatment could relieve the difficulty with less risk. The uterine canal exists in its integrity

so far as regards its caliber; the condition may be compared to a lead pipe, forcibly bent on itself, where its diameter is occluded mechanically. An inter-uterine stem is objectionable; he who would introduce a straight instrument into the organ under the circumstances assumes a responsibility, according to my experience, not to be repeated. If the stem to be tolerated is bent to the curve of the organ, the result is negative. Neither is the end to be gained by a gradual change of curve, even if an attack of pelvic cellulitis has not been a result of the undertaking; so long as the primary cause exercises its influence, the organ will immediately assume its wonted position on the removal of the same. Like a crooked tree which has attained its growth only at the expense of the integrity of its fibres, it will immediately assume its original condition, as soon as the opposing force restraining it in an opposite direction has been removed.

A large hospital experience led Dr. Sims, some years ago, to abandon all methods as unsafe and negative in result, for the relief of this condition, except the incision of the neck, as proposed by Prof. Simpson. My experience since has fully corroborated his teaching; we agree perfectly in principle, and only differ in the method by which it should be done. His ingenuity suggested an incision of the posterior lip directly backward in the median line; but after a few operations he abandoned this method as unsatisfactory. By subsequent observation of these cases, I satisfied myself that they could not be permanently relieved by either operation, as the seat of difficulty (as will be seen hereafter) was entirely above the point reached by the incision. He has since, I believe, practised Simpson's method entirely, although, judging from some of his late valuable contributions to the London Lancet, while

he has not been uniformly successful, he still regards that operation as promising the best results.

I am satisfied that neither operation will permanently relieve any case unless the flexure is confined to the neck and is below the vaginal junction. While the backward operation as proposed would relieve a moderate flexure, the lateral one, however, even if extended on each side to the vaginal junction, could not accomplish so much, unless the posterior flap, in the process of healing, retracted sufficiently to clear the seat of stricture, which it could not do. The dysmenorrhœa invariably returns after a few months, as soon as the mere revulsive effect of the operation has subsided.

The explanation to be offered is, that the posterior lip, lying on the floor of the pelvis, with the weight of the viscera above pressing the organ downward, would keep the two surfaces sufficiently in contact still to retard the menstrual flow in its escape, although the sound might be readily passed.

The representation repeated by all works on anatomy, in locating the uterus on a line of the superior strait, is not strictly correct. Some approximation is reached, it is true, yet, in a woman who has borne children, or who has suffered from uterine disease, (unless the organ be retroverted,) the cervix is found resting either on the rectal septum or on the floor of the pelvis. The objection, therefore, to the lateral operation in consequence of this pressure on the posterior lip, is tenable.

The position of the uterus is not appreciated by the use of the ordinary speculum, as its length in conformity with the accepted position must push the organ before it.

If a female is placed on the back, with the extremities flexed, and the perinæum firmly pressed back as far as pos-

sible by the thumb, the cervix will be brought into view in all who have borne children; the length of the perinæum being the only obstacle where it cannot be readily demonstrated.

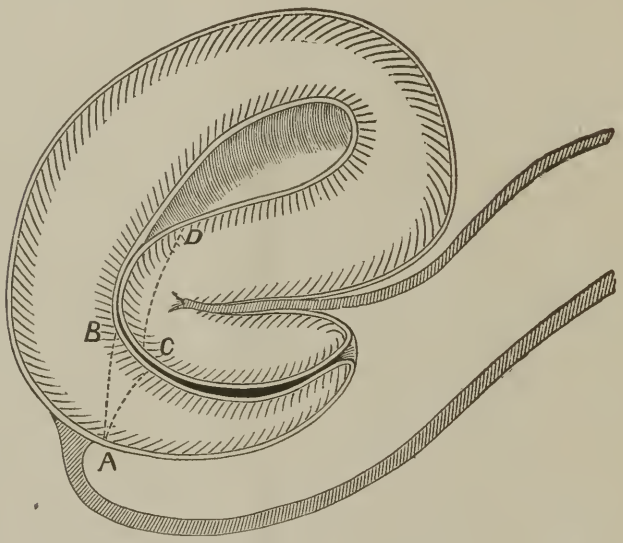
In cases seeking relief, a change has been going on for years, with every deviation of flexure from a simple version, until a condition has at length been reached approximating to that represented in the diagram. In this case, complete atrophy of the body has not yet taken place, except on the anterior wall at the seat of flexure. The canal is also shown above the flexure as dilated in consequence of the menstrual accumulation. This dilatation at times takes place to such an extent as to give an idea of hypertrophy of the uterus, while in fact the walls are thinner than natural. As soon as menstruation becomes scanty or ceases entirely, the organ collapses, and we recognize a state of atrophy. On carefully introducing a uterine probe which has been bent to the curve of the organ, the passing of the point of constriction will immediately be recognized, for the resistance to the instrument will cease so suddenly as to convey the impression of perforation. When this dilatation exists, the secretions are retained long enough to act as an irritant on the lining membrane along the course of escape, causing vaginitis, or pruritus, on coming in contact with the atmospheric air at the outlet of the vagina.

By referring to the diagram, it will be seen at a glance that a simple division of the posterior lip, extended backward even to the vaginal junction, could not relieve the difficulty, as the seat of constriction is still above the point reached by the incision.

In such cases, for the purpose of straightening the canal, I have found it necessary, in addition, for their relief, freely to

divide the angle of flexure formed by the doubling of the anterior wall of the uterus upon itself; without this step, no permanent relief can be obtained. It must be done boldly, with the view of opening the canal perfectly; but at the same time it should be borne in mind that, without a due realization of the danger, with the parts in a state of fatty degeneration and the uterine walls so thin at this point, a perforation is possible. The danger, as in any other operation, however simple, has only to be appreciated by the careful operator for its occurrence to be avoided. I can fully corroborate Dr. Sims' testimony as to the degree of risk in a simple division of the cervix. During the past six or seven years, we have performed the operation several hundred times for various purposes, in hospital and private practice. As a result of this experience, it may be stated that, wherever there has been no previous pelvic cellulitis, and the after treatment is conducted with the necessary care, no minor operation of surgery is attended with less pain or risk to the patient. Before describing the operation, it must be stated that the use of Sims' speculum is indispensable both for its performance and for administering the after treatment. The patient must be placed on the left side in the position recommended by him. The legs are to be well flexed on the abdomen, the right one rather more than the lower one; the body must be rolled over flat on the chest, and the left arm withdrawn from under the body and flexed over the back. It is moreover necessary that all the clothing of the patient should be loose around the waist. This position and instrument gives a facility for examination to be gained by no other method. The principle is to draw backwards the perinæum, which exposes the uterus in situ.

The proper time to perform the operation presented is directly after the cessation of the catamenia. The patient, having been prepared by an evacuation of the bowels the night before, is placed in position, the speculum introduced, and the uterus brought into view. The anterior lip is firmly seized by a



tenaculum, and the posterior one divided in the median line to the proper point by a single cut of the scissors. A small sound, properly flexed, is then passed to the fundus, and the blade of the universal-jointed uteritome is introduced, with its cutting edge backward, to divide the triangular space, A, B, C, formed by the inner blade of the scissors moving in an arc of a circle. The sound is still retained in situ, and, on reversing the blade, it is passed alongside as a guide, cutting the constricted point from C to D, and enlarging the passage, if necessary, as it is withdrawn. This completes the operation.

The immediate danger is from hemorrhage, if, by accident, the circular artery lying in the loose cellular tissue around the neck of the vaginal junction has been wounded. From the position of the uterus elevating that portion of the cervix in the vagina, the cellular tissue immediately behind is somewhat relaxed. When the neck is drawn forward for the operation, this tissue assumes a somewhat triangular shape, with its apex in the line of traction, terminating just at the junction of the vaginal tissue with the neck. The rule is to incise in this direction nearly to the apex, but never beyond it. Short of this point is a valuable guide in the operation to avoid wounding the artery, and one seldom absent.

I have for several years in this, as in all other operations of obstetrical surgery, substituted, as far as possible, the use of the scissors for the knife. Although they may be deemed less surgical, I have satisfied myself that I can operate more rapidly, and certainly have experienced less hemorrhage with them. The scissors that I have been in the habit of using for this operation are flat on the face, but have the blades curved at an angle from the handles, so as to conform somewhat to the direction of the uterine canal. Simpson's uteritome is not applicable to this operation, and cannot be used except where the canal is straight. Dr. Sims introduced an instrument having a narrow, cimeter-shaped blade, about an inch and a half in length, which answered admirably for the purpose; but, having a single joint, the blade can only move in the one plane; and to cut in the opposite direction it is necessary to have a second instrument with the reverse. This difficulty led me several years ago to have an instrument made with the same shaped blade, but terminating in a ball at the seat of the joint and separate from the instrument. The handle, being con-

trived like a pair of forceps, grasps the blade firmly in a socket at the required angle. It being, in fact, a universal or ball-and-socket joint, the blade may be used in any direction, and it is a valuable instrument for other purposes.

The representation in the cut is taken from the perfected instrument made by Wade & Ford, of this city. To their ingenuity is due the application of the principle. The representation is half the size of the instrument, but the blade at full size is out of proportion, as it should be represented both longer and narrower.

Having completed the operation so that a sound with the ordinary curve passes freely, a portion of lint saturated with glycerine is introduced well up between the cut edges; over this is laid a pledget, wet with a solution of alum, and the vagina is thoroughly tamponed with damp cotton, as if a hemorrhage actually existed. This is the only safeguard against its occurrence, which should be anticipated in every case. Before this lesson was taught by experience, I had seen secondary hemorrhage occur, (even days after the operation,) which persisted for hours in spite of all means to arrest it, and from which the patient's life was saved with the greatest difficulty. After the operation the patient should be lifted into bed, and not allowed to assume the upright position for

some ten or twelve days. Opium should be used if necessary, and the bladder evacuated either with a catheter or on a bedpan in the horizontal position. If after a few hours restlessness is caused from the pressure exerted by the tampon, a small portion may be removed, the patient lying on the back. On the second day the entire tampon may be removed, with the exception of the portion between the cut surfaces. This will become free, and be thrown out in a few days, but must not be disturbed beforehand. Daily afterward, while steadying the organ with a tenaculum, a sound must be passed to the fundus, drawing the point through the cut in the anterior wall, and pressing the instrument firmly backward in the division of the posterior lip on its withdrawal. This must be done without force, but more thoroughly each succeeding day, for the purpose of preventing the surfaces from closing by granulation. A glycerine dressing is to be introduced afterward, and the tampon carefully replaced. After a few days, if the edges are healing satisfactorily, without any undue bleeding, the tampon may be daily diminished in bulk, and discontinued entirely, after ten or twelve days. Should hemorrhage of a serious character occur, it is to be arrested in the following manner: The neck is drawn well into view, and on the instant of the removal of the blood by a probang sponge, in the hands of an assistant, the operator should freely cauterize the surfaces with a stick of nitrate of silver, then with a number of small pieces of sponge he should pack firmly between the divided surfaces until filled, and secure the whole by a compact vaginal tampon. The sponge tampon is to be left until loosened by suppuration. The operation should never be attempted without one or more assistants in readiness to meet this emer-

gency. The different styptics of iron are almost useless, as they cannot act readily on a surface from which blood is rapidly flowing. By means of bits of sponge saturated, and by careful pressure, it is true that the hemorrhage can be frequently controlled by this means. But if the effort has not been successful, and it becomes necessary to make another attempt, the vagina will be found so much contracted as to complicate the operation exceedingly. Unless the preparation is perfectly fresh, from the fact that almost always some free acid exists, the vagina becomes so very irritable for days afterward as to add greatly both to the discomfort of the patient and to the difficulty of giving the necessary after treatment.

After discontinuing the tampon, the sound should be passed every other day. As long as any discharge continues, large vaginal injections of tepid water are useful.

The first menstrual period is frequently (although not always) more painful than usual, consequent upon the engorgement resulting after the operation, and from which there has not yet been time fully to react. The period should be spent in the recumbent position, and every effort made to assist nature in properly performing the function.

After its cessation, a most important part of the treatment has to be instituted.

Follicular disease throughout the lining membrane of the canal has existed for years, with various inflammatory changes, involving other portions of the organ, and resulting either in hypertrophy or atrophy, and induration. Although a most powerful stimulus has been given to the reparative process by the operation, and one without which but little could be accomplished, we must now treat the inflammatory condition and its results.

My mode of treatment is to apply chromic acid (in a solution of water of equal parts) once or twice a month, to the entire uterine canal. This is applied on a bit of cotton, twisted around a thin, flat, silver probe, which I have had made for the purpose. A small sound is first carefully introduced, and the curve altered until the exact sweep of the canal is obtained; the probe is then bent to correspond, and the application made. The cotton should be merely saturated, without there being any excess of fluid. An important point in making the application, is to steady the uterus by seizing the cervix with a tenaculum; it facilitates the operation, and gives less pain. As a rule, a diseased uterus should be treated as an inflamed joint—it should be as little disturbed as possible in its chosen position. The patient should be immediately placed in bed, and kept confined for some ten days. As long as any discharge continues (not the result of treatment) the applications are to be repeated after each menstrual period. After the thin film produced by the application has been thrown off, which is usually in from a week to ten days, Churchill's saturated tincture of iodine may be used every four or five days, applied in the same manner. Daily dressings to the vagina, of a portion of cotton saturated with glycerine, are useful. A string should be attached, so that the patient may remove them after eight or ten hours, when she feels any inconvenience from their presence. The value of *pure* glycerine as a disinfectant, and for its local depleting effect on the capillary circulation, in consequence of its affinity for moisture, is not yet fully appreciated by the profession in the treatment of uterine diseases. Throughout, daily injections of tepid water are valuable; the quantity should be large, and the temperature increased with the degree of heat and soreness com-

plained of. A bedpan is necessary, and should be used with the patient placed in the horizontal position. The injections must be given by a nurse, as it is impossible for the patient properly to administer them herself.

A few words should be said in relation to the use of chromic acid. It is a most valuable agent; and for its introduction into use for the treatment of uterine diseases we are indebted, I believe, to Dr. Sims. A solution of the strength I have mentioned, is far more efficacious than nitrate of silver, while, unlike the latter, and all other remedies in use as local agents, it does not produce induration of the tissue by continued use. It is productive of less pain than any means that we have at command; its action is limited and gradual, and only attacks diseased tissue. In a concentrated form, it is more powerful than nitric acid; but, from its ready solubility in water, solutions of various strength are applicable to an extended field of usefulness in the treatment of uterine diseases. In some ten years' experience of its use in Dr. Sims' practice and my own, I have seen but one attack of metritis follow its use, in a case where it was applied with a camel's hair brush freely to a dilated canal, through mistake, for the tincture of iodine. What the effect might be in ordinary use, and with less care, I am unable to state, as I never use it without placing the patient immediately in bed, and keeping her there for several days, until its active effects have passed.

I have performed this operation for the relief of dysmenorrhœa and sterility from anteflexion, between forty and fifty times. To the best of my knowledge, not a single bad consequence has followed its performance, and in every case which has since passed under my observation I have felt every reason to be gratified with the result. I have been able to ascertain

that nine of the number shortly afterward conceived, and passed through their first pregnancy in a satisfactory manner. In one instance, the first pregnancy (four months from the operation) took place eleven years after marriage, and went to a successful termination. Two members of this Society, at least, have attended, to my knowledge, in the delivery of a case each, and can bear witness how far the operation exercised an influence on the progress of labor.

I will give an outline of the history of these cases, and others of a different type, but in brief, as I have already entered so fully into the details, both of the operation and the treatment.

Mrs. I., aged 20, came under Dr. Sims' care in April, 1862, a short time before his removal to Europe. From the history of her case, she had at that time been married about a year, and was sterile. She had always suffered from dysmenorrhœa, and from menorrhagia about three years. The uterus was enlarged, and anteverted, with a moderate degree of flexure. She came under my observation in the fall of 1862, with all her previous symptoms aggravated, and the uterus completely anteflexed. Late in November, I operated, and gave her a chromic acid application a few weeks afterward. She greatly improved, and in the following January became pregnant. Dr. Elliott attended her, and since her delivery she has been in excellent health.

He informed me that the labor was perfectly natural, the dilatation of the cervix unusually prompt, and the progress of the labor more rapid than he had anticipated. She is again pregnant, and expects to be confined early in October next.

Miss N., aged 18, placed herself under my care in April,

1863. She menstruated for the first time at 10 years of age. She remained in good health and free from dysmenorrhœa for five years. In 1860 she was exposed to cold during the catamenia, which suddenly arrested the flow; this was followed by an attack of illness, which confined her to the house for several weeks. Since this time the flow had been exceedingly painful and was always accompanied with violent hysterical attacks, which were regarded by her physicians as being epileptic. The length of the flow had been increased from four days to six and seven in duration, but scanty in quantity, irregular in time, and painful throughout. Her depression of spirits had become so great as to make her fearful at times that she would become insane. During the previous year she had been confined almost entirely to her bed, in consequence of an inability to stand, from pressure on the bladder, and had, to a great extent, lost the use of her lower limbs. There had been but little vaginal discharge, except for a few days after the menstrual period, although she suffered constantly from pruritus. On making a vaginal examination, the uterus was found larger than natural, with a well-marked anteflexion, its seat being above the vaginal junction. The sound, after the frequent alteration of its curve, was passed with the greatest difficulty. After passing the seat of constriction, the canal was very much dilated. There was no increase of pain from pressure, except when the finger was passed along the base of the bladder, so as to make pressure on the anterior wall of the uterus, and the whole organ was less movable than natural. The diagram given as a type was copied from the one that I made at the time, in my case book, as representing her condition.

May 3, 1863, I operated (as shown by the diagram) two days after the cessation of menstruation. May 29 the period

came on naturally, free from pain, and lasted five days. June 6 I applied chromic acid to the fundus uteri, and repeated it on the 20th inst. July 12 she returned home, entirely free from all nervous symptoms. April 26, 1865, she called on me, and had so entirely changed in her appearance that I did not recognize her. I found, on examination, the canal perfectly straight, with the uterus slightly anteverted, and of a normal size and condition. She stated that she was in perfect health. The catamenia was natural and lasted five days. She had increased fifteen pounds in weight since her return home, now nearly two years ago.

Mrs. S., aged 26, consulted me January 3, 1864. Menstruated for the first time at the age of 10. From the beginning, dysmenorrhœa had existed, on the first day or two of the flow. She had been married about six years, and was sterile. Since marriage, her health had become greatly impaired, and the menstruation more painful and scanty, and withal she was exceedingly nervous. In consequence of a visit to a warm climate, she had contracted chronic diarrhœa, which enfeebled her general health very much. She had returned to this country almost a year before consulting me, and had then recovered her general health. No improvement, however, had taken place in the menstrual function, and she was still as nervous as before. On making an examination, the cervix uteri was found to be long, and very much flattened transversely; I could make no better comparison of its shape than to that of a scoop. The flexure was entirely within the vagina, just below the junction: the body was rather smaller than natural, and but slightly anteverted. The relation of the body to the neck was nearly at a right angle. The seat of constriction was about midway, making the cervical portion about equal in length to the

body. The neck was soft, its lining membrane within the os of a deeper color than natural, with but little cervical discharge. I divided the posterior portion of the lip backward to the seat of flexure, which at once opened the canal, making its course perfectly straight. Three weeks afterward she menstruated for the first time in her life free from pain. As the organ seemed otherwise in a healthy condition, I gave her no further treatment. She conceived within two months afterward, went to full term, and was delivered, after a natural labor, by Dr. Henschel. Up to the present time she has continued in perfect health.

The case referred to as having become pregnant after being eleven years sterile, was a case similar in every respect to the one just stated. The seat of stricture was a limited point, and the only cause of the dysmenorrhœa and sterility. With the exception of being very nervous, she was in good health. As is always the case when the seat of flexure is below the junction, and does not obstruct the circulation, except during the menstrual period, little or no structural change existed in the body. This form of sterility, with the length of the neck varying in each case, is exceedingly common, and is readily relieved.

Drs. Thomas, Winston, and Perry can also add the weight of their testimony in favor of the operation. The former gentleman, having operated, has at the present time a lady under his charge who is three months advanced with her first pregnancy—a case, I am told, that was at first far from being a promising one, having suffered from dysmenorrhœa all her menstrual life, resulting in complete prostration of the nervous system. The operation at first did not relieve the dysmenorrhœa, but the subsequent treatment was successful, two years after marriage.

Mrs. G., aged 22, menstruated for the first time at 14. The flow was always scanty, and excessively painful during the first day. Her health was not perfect, but she was never confined to the house until after her marriage, at 19 years of age. Immediately after this time, the menstrual flow became lengthened from four to eight days, but the quantity was, in fact, rather lessened, and the menstruation more painful. She became a confirmed invalid, and was confined to her couch. She stated that the anticipation of suffering, in advance of each period, destroyed all her happiness, and made death seem a blessing to her. In addition to an excessive degree of nervousness for two years past, she had suffered from constant pain over the left ovary, increased in the upright position, with irritability of the bladder. I found her case the most extreme one of flexure that I had ever met with; the body hypertrophied, and the neck small and pointed. I operated, and within twenty-four hours there was a marked improvement in the condition of her nervous system. I made two applications of the acid, and several of iodine, and attended to the improvement of her general health. Late in November she returned home, having menstruated more freely, but without being entirely relieved from pain. She continued to improve without further treatment, and in the February following became pregnant. She has since been delivered; at the present time is in perfect health, and is, I believe, again pregnant.

It is unnecessary to offer the history of a greater number of cases as types of illustration. In those already presented, the object has been accomplished. As I have dwelt with so much stress on the necessary after-treatment, without which little could be accomplished, the operation may be regarded as unnecessary. I have never had a fact more fully demon-

strated by experience to the contrary, and without it a large. class of cases can never receive any benefit from treatment, In nearly every case endometritis has existed for years. This, however, seldom comes under observation until its result, in an impaired nervous and organic system, imperatively demands relief. The surgeon should be just to himself, and with a full appreciation of the insidious progress of the disease, he should not mislead either the patient or himself as to the result in such cases of long standing.

Both from delicacy in seeking early advice, and from the imperfect knowledge of so large a portion of the profession beyond a routine treatment of uterine disease, the female has continued an uncomplaining sufferer from early puberty to late womanhood before she has realized that she has borne more than her lot. I have had such cases under my care for years, and have been able to make their condition very comfortable, but I can not regard them at any time as cured so long as the menstrual function continues. The tendency to a relapse is unceasing, and can only be counteracted by the constant care both of the patient and physician. I am happy to state, however, that these cases are but the exceptions, and while so much has been already accomplished, we must not despair in any case for the future. The ratio of success is according to the previous duration of the disease, and the professional adviser is culpable, where the uterine disease is so evident, in leaving the case of a young female to Nature—a task which she cannot accomplish unassisted.

The most feasible objection to be made to the operation is the apparent mutilation of the neck; this, however, is only a temporary result. Just in proportion as the inflammation of the body is lessened, after the dysmenorrhœa has been relieved

by the operation, the body will return to its natural position in health, and the neck will become shorter and broader. By the same result, the long incision becomes nearly circular, and contracts; so that, after a few months, the os presents but little change from a normal state. This is not the result of contraction from cicatrized tissue, and offers no obstacle to the progress of labor; the parts merely retract, the tension having been removed.

Madison Avenue.