ON THE MECHANISM OF SPONTANEOUS ACTIVE UTERINE INVERSION, AND THE REDUCTION OF A CASE OF COMPLETE INVERSION BY THE COMBINED RECTAL AND VAGINAL TAXIS

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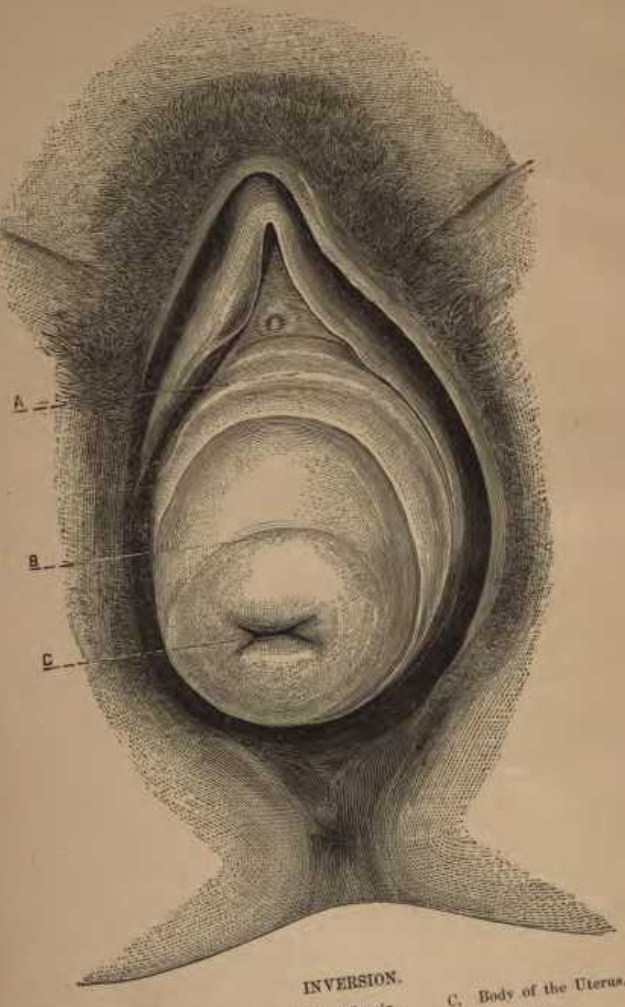

INVERSION.

A. Os Tincæ. B. Extent of Cervix. C. Body of the Uterus.

EVERSION.

A. Os Tincæ. B. Internal Os.

ON THE MECHANISM

OF

SPONTANEOUS ACTIVE UTERINE INVERSION,

AND THE

REDUCTION OF A CASE OF COMPLETE INVERSION BY THE COMBINED RECTAL AND VAGINAL TAXIS.

BY

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ON THE MECHANISM OF SPONTANEOUS ACTIVE UTERINE INVERSION, AND THE REDUCTION OF A CASE OF COMPLETE INVERSION BY THE COMBINED RECTAL AND VAGINAL TAXIS.[1]

Of all the physical lesions of the uterus, that which appears the most extraordinary is produced by a kind of displacement which the organ executes, that is to say, upon itself, and reversing entirely the order of Nature, partially or wholly.

I propose this evening to present some observations on the mechanism of spontaneous active inversion of the uterus in the unimpregnated state, in the recently confined, and on the re-inversion of that organ. I shall also make some remarks, with a recital of a case of complete inversion of the womb, treated by a different method than is usually resorted to, and refer to some of the more recent methods of treatment adopted at the present day. I desire to be expressly understood as excluding those cases of inversion which occur through artificial or external means. I shall adduce those cases only where the

[1] Read before the Academy of Medicine, April 4, 1872.

cause is inherent in the uterus itself, the same as we notice in other viscera by their own action, whether in the human or animal creation.

I need not suggest the names of any authorities at the present time to prove that cases of spontaneous intussusception, invagination, or inversion of the uterus, have and do occur. Facts are too numerous to merit a negative reply, especially in those instances which take place at the time of labor, or after an interval of some days. The occurrence of this unfortunate accident in the female who has never had children, or been pregnant, is, in the opinion of some of the modern gynæcologists, a great mistake. The evidence, according to their experience, is, that it is impossible in the unimpregnated uterus. They believe that it is obviously essential for its occurrence that the organ should have attained a certain size, and that its walls should be comparatively ductile. West does not positively deny its taking place, provided its parietes should be yielding. Duncan, the latest writer on the production of inversion (1868), says: "I shall only say that I cannot believe that such an inversion ever occurred."

Within the last few years the attention of the medical profession has been more particularly directed to the manner of replacing the uterus, after its inversion, to its natural position, on account of the success attending personal and persevering efforts, than to an investigation into the special causes of the inversion, and the mechanism during the act. Methods and processes have been advanced and claimed as new, which are in fact older views resuscitated without conceding the credit to the just and proper authorities they were "based on." The study of the mode of the production of inversion would seem to have been in abeyance, and the truthfulness of the interpretation of its mechanism or progress has been regarded as absolutely settled.

Judging from the discordant opinions which are entertained by some standard authorities on inversion, anatomically and physiologically, I have thought, independent of the views I will offer regarding its production, it might be well to resurvey some points which have a bearing on the subject, and which would be opportune and applicable at the present

moment. A resurvey of this important subject may prove beneficial. It is very difficult to appreciate all that has been done on any one subject without retracing our steps and scanning the various opinions as to its mechanism and treatment. It is possible it might be considered superfluous and useless, as the opinion has been expressed that any other view than the ancient one would simply be an inference or an impossibility. I am willing, nevertheless, to accept this charge, and will proceed to ask your attention to the subject. The views and opinions I hold I am fully aware are not in consonance with those of the profession, but this ought not to deter me from presenting them, as they are the results of long and continued thought, with no limited amount of experience in uterine and obstetrical practice, public and private. I intend presenting such cases as will clinically suggest another aspect besides the generally-received one of how the inversion takes place. The usual views are:

1. That the fundus of the uterus is always the part first indented or depressed, and the uterus in a state of partial or complete inertia.

2. That it may occur when there is active contraction of the body and fundus.

I wish to remark, on these propositions or theories, that I do not deny that the fundus is the part first depressed, as in a passive condition of the uterus when in state of inertia or functionally paralyzed, by artificial means, as the traction on the cord, or too short a cord, or by the forceps, or by small and large polypi, and when the long obstetrical forceps may be applied to deliver the polypus. I have on several occasions had the opportunity of operating by the latter means, and have noticed the manner of inversion.

In our profession there is not one who does not recognize and realize how great the difference of opinions and views is we hold on the same subject, and from the same stand-point. By a different process of investigation, and experience, and reasoning, we may present another explanation, although the same result will be obtained, as equally satisfactory.

It is usually conceded that inversion of the womb is a rare accident. It is my firm conviction that this opinion is incor-

rect. My impression was confirmed in looking over the large number of cases which are recorded in the different journals and transactions. Many members of the profession, it is true, have been engaged in practice for years, and have never met with a case. Prof. Simpson, it is said, had never seen a case of acute inversion. This, however, is no argument in favor of its rarity. They may have been fortunate in the management of their obstetrical cases by not making traction on the cord, or the harsh removal of the placenta, and believe that they have thus prevented its occurrence. Reference has by many authorities been made to the large number of cases of labor occurring in the Rotunda Hospital, Dublin, as a proof of its infrequency. From the statistics the inference has been drawn that it must have been from the great care, attention, and management, bestowed upon the delivery of the placenta, with little or no pulling on the cord. Dr. More Madden, in his article on "Acute Inversion," in the *Dublin Journal of Medical Sciences*, November, 1870, states that "up to the end of the year 1868, when 190,883 women had been confined in the hospital since its foundation in 1745, only one case of acute or recent inversion was observed, nor has any happened since then." Desormeaux and Dubois entertain a different opinion. Dr. Radford, of Manchester (1837), is also inclined to think so, and cites the evidence of others in favor of that view. Some members of the profession have informed me that they have met with several cases. Silence on the subject has been observed by some, who have thought censure might be attached to them for bad or careless conduct of the case of labor. Instances, therefore, of cases under such circumstances, if they had been reported, would have swollen the list of frequency.

Experience at the present day shows also that spontaneous inversion is considered as frequent as the cases from artificial sources or mismanagement. Dr. McClintock, nevertheless, writing as late as 1863, says: "I cannot help expressing my conviction that, whenever the uterus is inverted at the time of parturition, it is to be attributed to some mismanagement of the delivery of the placenta, and in confirmation of which I adduce the accumulated experience of Drs. Clarke, Labatt, Collins, Kennedy, and Johnson."