HOMEOPATHIC JOURNAL OF OBSTETRICS, GYNECOLOGY AND PEDOLOGY. VOL. XX, NO. 4, JULY 1898; PP. 297-396

Published @ 2017 Trieste Publishing Pty Ltd

ISBN 9780649443291

Homeopathic Journal of Obstetrics, Gynecology and Pedology. Vol. XX, No. 4, July 1898; pp. 297-396 by Various

Edited by Trieste Publishing Pty Ltd.
Cover @ 2017

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Trieste

THE HOMEOPATHIC

JOURNAL OF OBSTETRICS,

Gynecology and Pedology.

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133 William Street, New York.

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A. L. CHATTERTON & Co., Publishers, New York.

No. 4. *July, 1898.* *Vol. XX.*

BACKWARD DISPLACEMENTS OF THE UTERUS.

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Read before the American Institute of Homeopathy, June, 1898.

Retroversion of the uterus implies permanent dislocation backward with the axis of the body and the axis of the cervix essentially identical. Retroflexion denotes the permanent backward dislocation of the fundus, the cervix remaining in situ or participating in retroversion, the axes of the two parts forming an angle. In rare combinations retroversion with anteflexion or anteversion with retroflexion may coexist. The degree of backward dislocation is always a matter of relativity, and with the woman in the upright position is greater as the axis approaches the horizontal. Retroversion and retroflexion have intimate relationship, the former being usually a transitory condition originating the latter. It must not be understood that every retroflexion has retroversion as an antecedent, but that it is very frequently the case and that the two con-

ditions have common causation. Practically they are found to coexist in many cases and must receive conjoint consideration. Whether it be retroversion, retroflexion or retroversio-flexio, matters little so far as etiology and principles of treatment are concerned.

Uterine position has wide latitude within normal limits. Situated between organs subject to distension and collapse, the uterus may be pushed forward or backward through a space of several inches as the frequent daily needs require. It may rise and fall to an equal or greater extent as is shown by sneezing, tenesmus, the genupectoral position and respiration. Its lateral mobility, while not so great, is yet marked and rotary motion is in some degree possible. Having no solid foundation upon which to rest, and being suspended in mid-pelvis by guy ropes and attachments more or less elastic, it may disport itself as a trapeze performer in executing any movement within its physical capabilities. Whether it rise or fall, lie prone or decubitus, traverse with its fundus an antero-posterior arc of sixty degrees, or make obeisance in its flexions to any point of the compass, is of small consequence so long as it shows its ability to regain and maintain itself. The positions assumed may be regarded even as anomalous, but so long as the uterus is able to return spontaneously to its normal position after the transient cause of the deviation has ceased to operate, it cannot be charged with displacement.

Uterine displacement cannot be diagnosed in the clinical sense until the deviation from the normal has become more or less stable. There must be limitation of automatic movement, prolonged departure from normal position and inability to maintain that position when regained to fulfill the requirement. In displacement passive movement may be in no sense circumscribed, the uterus may remain even abnormally movable, but active and independent exercise is more or less suspended, self adjustment is impeded and normal ability thwarted.

Uterine displacement, therefore, implies the embarrassment or obstruction of definite normal movement and the suspension in part or whole of normal ability. The play of forces incident to normal exercise has been disturbed and the equipoise lost. Natural prowess no longer obtains, an enervated and toneless

organ is encountered and forces rule that dominate all passive bodies—I mean particularly the force of gravity. Especially is this true of all backward displacements of the uterus inasmuch as the consideration must embrace not only the weight of the helpless decubitus uterus, but the superimposed bowels pressing down upon its anterior surface, instead of forward upon its dorsum as in the normal position.

Backward displacement may be evoked primarily by any cause which may induce intensification of intra-abdominal pressure. Lifting a heavy object, violent vomiting, prolonged coughing, a blow on the abdomen or a fall in which the sacrum receives the impact, may serve as the initial. Even an habitually distended bladder may impinge upon the uterus so continuously as to engender permanent displacement. But while incidents of this character may serve as direct cause, there is in each instance a predisposing cause or antecedent condition of the system that must be regarded as part of the problem. Incidents capable of serving as the cause direct are of daily occurrence in the life of every woman, but it is only in cases of enfeebled or crippled vitality that they prove effective. When the life forces are regnant, uterine ligaments—contractile tissues—like the drawn bow of the archer spring back the moment the pull is relinquished, obliterating all evidence of displacement. It is only in cases of mal-nutrition and enfeeblement that elasticity is impaired, that power to regain the erect is wanting and that the uterus continues to lie after it has fallen.

It is clear that a comprehensive grasp of the subject cannot be gained without considering the antecedent factors potent in the production of this anomaly. Rigid induction has disproven the opinion held for a long time by most gynecologists that the predisposing causes of retro-displacements in the majority of instances were chargeable to puerperal experiences; that inasmuch as most victims of the misfortune are found among those who have borne children, the causation was, therefore, due to some mal-performance during the puerperal state. Careful clinical study has shown that while the larger quota of such patients are thus found among post-parturients, the pelvic weakness and liability to displacement, if not the dis-

placement itself, was in evidence before the first pregnancy, and the deviation was established or re-established in the puerperium because the uterine attachments were in the beginning relaxed.

This is in accordance with the observation of Kustner, that uterine displacements, or the tendencies thereto, "have been carried over into the sexual life from the time of puberty and puerility;" and proves that errors of development underlie most, if not all, of the cases, and that malnutrition is the universal factor. While the argument in no sense belittles the agency and importance of the puerperal factor, it justly emphasizes the necessity of the early and full development of the female sexual organs. The partial or complete arrest of the development of the uterus and adnexa is present in our day to a most surprising extent. The number of girls who reach the age of twenty with sexual organs in an infantile or dwarfed state is alarmingly great. Whether this be due in our cramming educational process to the diversion of the nutrient blood-supply from the pelvic organs to a precociously developed brain; to the metastatic influences of zymotic diseases during puberty; or to indiscretions due to ignorance or wilful disregard of menstrual demands, I cannot now discuss. I note the fact as a reason for more rigid censorship over those girls, especially who are contemplating marriage, and over all who in any way manifest sexual embarrassment or inability, or who give evidences of sympathetic disturbances. Enlightened thought on this subject demands that all girls shall be free from the handicap of sexual non-development before marriage is entered upon and whenever embarrassed functional evidences are announced. Motherhood should never be essayed by one possessed of organs wholly incapable of completing the act without extra hazard or catastrophe. Uteri and uterine attachments which ceased to grow at the age of thirteen or thereabouts, should not be allowed to attempt the responsibilities which are safely and easily discharged by organs of full maturity. To this effect there must be a recast of views upon the subject of early physical examination in all such cases. Invalid and markedly undeveloped girls must undergo the rigid scrutiny demanded in all such instances. They must be

the recipients of such remedial help as is afforded by the gynecological resources now developed. Their sexual helplessness must be supplanted by that vigor and tone which is the birthright of every one and without which capability and the creditable discharge of normal function is an impossibility.

I have purposely dwelt upon this phase of the subject because I consider it to be the chief factor in the remedy of all utrine displacements. I mean (1), that the establishment and possession of such vigorous organic ability would be an effectual bar to the development and continuance of such forms of incompetency before the advent of child-bearing; (2), that it would insure freedom from most of the perils of parturition evidenced by the well-known train of sequelæ, and, (3), that no cure of uterine malposition can be attained without regainment of normal vitality—both local and general. Wisely directed treatment, therefore, must in the first place anticipate the effects of the force of gravity upon a helpless organ by insuring the proper development of that organ; it must by prophylaxis hedge against the possibility of uterine and adnexal disability; it must see to it that every young woman is possessed of her full complement of life-energy, both local and general. I say the work of the gynecologist properly begins before the announcement of uterine instability; and is, ideally, of the order of prevention rather than patchwork.

Unfortunately this wise exercise of our knowledge is too rarely permitted. The faulty practice now is to wait till the weakness is engendered; to withhold help till mal-position has become stable. It is the up-hill work of reform; it is the regainment and re-establishment of energy lost that is, for the most part, called for in these days.

Coming from the abstract to the concrete, let us enter the clinical arena and deal with conditions rather than theories. Here is a girl under twenty, who is complaining of menstrual irregularities. The menstrual discharge is wanting; is too scanty of profuse, or is voided with great pain. She is, perhaps, constipated, a poor eater and has bad digestion. She has neurasthenia and faints away with or without provocation. She may be a consumer of slate pencils, chalk, plaster or other earthy matter, and is more or less incompetent mentally as

well as physically. A reasonable course of medication, calisthenics, reform of school duties and, perhaps, residence in health resorts, has been tried without permanent benefit. Before much time is squandered in fruitless effort of this kind she should be anesthetized and examination made of her clitoris, vagina, uterus, ovaries and rectum. Clitoral adhesions should be broken up, stenoses of sphincters overcome, papillæ of urethra, vagina or rectum removed, as well as every other occasion of sympathetic irritation. The diminutive uterus—displaced or not—must have rapid and thorough dilitation; the endometrium freed from all traces of vegetation, and the uterine muscle aroused from its dormancy by the induction of "mock labor." This should be accomplished by means of uterine packing with aseptic gauze continued through several hours or until nature makes protest in a slight rise of temperature, say from one to three degrees. The object accomplished by this latter step is the quickened and enlarged circulation of uterine vessels and a consequent better nutrient blood-supply to the starved part. Of course the treatment by divulsion and packing must be dependent upon the absence of acute inflammatory conditions in uterus and adnexa as well as all other contraindications. But her sexual forces must be freed from all thralldom and aroused to energy by methods simulating the normal and mature exercise. Such an embarrassed girl, I say, should never be allowed to reach conception or be forced to acquire uterine development after a possible impregnation.

It is remarkable how responsive nature is to such effort particularly through the first half of the child-bearing cycle. Development and growth of retarded female sexual organs is attainable in most cases at any age under thirty years, and while increase to normal standards at a later period is more problematical or wholly impossible, the removal of all occasion of sympathetic irritability is followed by such physical calm as is compatible with good health.

Whenever retro-displacements have been acquired in the nulliparous state regardless of age, the foregoing regime is applicable, subject always to such modifications as may be dictated by the morbid conditions present in the given case. Inflammations within and around the uterus should be over-

come, resultant adhesions absorbed or loosened up and tubal or ovarian degenerations ruled out before the employment of the radical measures here outlined. It must be remembered that a long decline of vital energy may have preceded your effort at cure; that uterine ligaments may have been under tension in such degree and for such time as to have acquired undue length and wholly to have lost elastic tone, and that a long directed effort may be called for in the re-acquirement of health conditions. To this end there must be persistent employment of the properly selected internal remedy; the uterus must be kept in right position for a sufficient time by wool tampon or other properly adjusted mechanical support, and every adjuvant utilized that will favor this accomplishment. Even then it may be ascertained that the elastic tone is irreclaimable, the ligaments and connective tissues are persistently lax and elongated, and that surgical shortening may be necessary.

Whenever retro-displacement has been acquired by the woman after parturition, the requirements of treatment are in many respects identical with those found necessary with the nulliparous, but may have in addition many new features. While the development of the puerile uterus has been accomplished in a measure by means of gestation, the parturient act has been inadequately performed and extensions and additional burdens have been imposed upon the state of pre-existent weakness. Cervical laceration, retained placental fragment or endo-metritis may have thwarted the performance of involution, and subinvolution of the uterus and its ligaments may have remained. In addition, the vaginal and perineal supports may have been weakened or swept away by rupture, thus obliterating all the restraint and sustained force of the pelvic floor. Under such circumstances the abnormally heavy uterus inadequately tethered by its lax and subinvoluted ligaments, like a top-heavy balloon, falls helpless and enters upon its course of descent. Prolapse is next in order and full procidentia a matter only of time. It is good fortune, indeed, if, in all this embarrassment, sepsis has not been superimposed and the ravages of inflammation are not an additional complication; or, if the cell-life in uterus or ovaries has not been