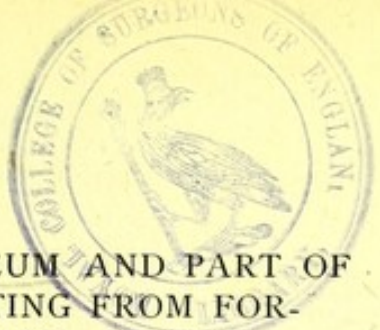
Complete laceration of the perineum and part of the recto-vaginal septum, resulting from forceps delivery : primary operation, complicated with traumatic erysipelas / by A.B. Cook.



COMPLETE LACERATION OF THE PERINEUM AND PART OF THE RECTO-VAGINAL SEPTUM; RESULTING FROM FORCEPS DELIVERY. PRIMARY OPERATION, COMPLICATED WITH TRAUMATIC ERYSIPELAS.*

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On the 10th of February last, about 8 P. M., I was summoned by a medical friend to visit Mrs.——, who married when 22 years old, and had been a widow three years, when, in April, 1884, she married her second husband. The first marriage was without issue. She is a well-developed woman, above the average size, and weighs 140 lbs. On inquiry I ascertained the case to be that of a primapara; duration of labor, 17½ hours; second stage, 4½ hours. The waters broke, in the absence of pain, during the first stage, when the os was thin, hard, and dilated to about the size of a silver half-dollar, vaginal outlet small, soft tissues, unyielding, the head large—circumference 14½ inches. The forceps had been used about 7½ P. M., and the soft tissues suddenly gave away as the head was about to emerge.

On my arrival one hour after delivery, a digital examination showed that the laceration commenced high up in the vagina, on the left side of the septum, tearing the tissues obliquely to the right, and exposing the fibrous investment of the rectum almost to the median line. It then passed downward obliquely through the septum and sphincter ani muscles, tearing the latter from the septum, at their junction with it, and then obliquely through the perineum proper, finally reaching the raphe at the verge of the anus. The wound measured in length six inches from the commencement in the vagina to the perineal center. The soft parts were much tumefied, the lochial flow was free, filling up and obscuring the extensive wound.

The patient was drawn to the edge of her bed and placed in the position for lithotomy. Anæsthesia was readily produced, she having been chloroformed during delivery, while the sensibility of the soft parts had been obtunded by the pressure of a large head. The lacerated wound favored the arrest of hemorrhage, and hence there was little trouble from this source.

The vagina, above the laceration, was plugged with sponges to prevent, as much as possible, the flow of blood into the wound, and a Sims speculum was introduced to expose the cavity, and held by an assistant. I then proceeded carefully and deliberately to operate. The ragged edges of the wound were clipped off with scissors, and then by the light of a lamp I passed the silver wire sutures. Four sutures were first passed, with Fischer's needle, through the torn septum; then five in the perineum, the first at the verge of anus. The needle was inserted on the left side, fully one inch from the edge of the wound, and carried downwards and backwards around the circle of the sphincter muscles,

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through the recto-vaginal septum, and out through the skin at a corresponding point on the right side. When the eye of the needle emerged through the skin it was threaded with the silver wire and withdrawn, leaving the suture in place. The second suture was introduced in a similar manner, about half an inch above the first, and carried also through the recto-vaginal septum to close it and completely draw it down and secure perfect co-aptation and retention between the septem and sphincters. The third suture was passed the full depth of the perineum and through the lower margin of the septum, the fourth and fifth closing the lower inch of the labia. The vaginal sutures were drawn sufficiently tight to co-aptate the edges, and secured by twisting with needle forceps. The perineal sutures were alternately tightened—commencing with the first—and twisted, while the ends were clipped off short. I prefer the plain twist, it is equally secure, less complicated, makes less traction and does less cutting through the skin. The more simply wounds—accidental or surgical—are dressed the better. It required less traction of the sutures to co-aptate the surfaces than in cases of old standing where cicatrices have formed and the soft parts contracted and retracted, while the hemorrhage was much less. After dressing the wound, the vaginal sponges were removed, the vagina syringed with hot water and anointed with carbolized glycerine, a catheter introduced to evacuate the bladder, the knees bandaged together, and the patient then placed in bed on her right side. To quiet pain, give rest, and lock up the bowels—the latter had been freely unloaded, and the stomach evacuated during labor—a half grain of morphia was given, and one-fourth grain ordered every three or four hours *pro re nata.*

The nurse was ordered to use the catheter every six or eight hours. The following morning the pulse was 96, temperature 101, and the patient was ordered a three grain capsule of bisulphate of quinine three times a day, one-fourth grain morphia every four hours, and hot water vaginal injections morning and evening, followed by two ounces of the following:

℞ Carbolic Acid, - ℥ ss. Glycerine, - ℥ iij.
Distilled Water, - ℥ v.———M. Ft. Sol.

The injections were supervised by myself. The diet consisted of sweet milk, Liebig's extract of beef powder, and, if desired, ice cream.

From this time until the night of the 14th the case progressed admirably, the pulse ranging from 94° to 98°, the temperature from 98° to 101°, and the wound appeared to have united by first intention—there being an absence of swelling and inflammation. There was no material change in the treatment until the morning visit on February 15, at 9 o'clock, when the patient stated that she had passed a restless night. The pulse was then 110°, and the temperature 102½°. An examination showed that traumatic erysipelas had developed on the left natis, the inflammation extending outward and upward toward the spine, inward to the edge of the wound and raphe. The skin was hard, elevated, and red, with little tenderness on pressure. The lochial flow had ceased, and the discharge now was slightly discolored, moderate in quantity,

and without any odor of decomposition. Used vaginal injection—three quarts —carbolized hot water, followed by the carbolized glycerine mixture: painted collodion over left natis, extending the coating two inches outside the erysipelatous blush, and ordered,

℞ Tr. Ferri Mur., - - - - - - ℥ ss.
Syrup. Aurantii, - - - - - - ℥ ij.

M. S. a teaspoonful in a wine glass of water every two hours. Continued the quinine as before, and one-fourth grain morphia every six hours.

The room was disinfected with freshly parched coffee, the parching being done in an open vessel on hot coals, and repeated two or three times during the day—result, rapid disappearance of all tainted atmosphere. 5 P. M. pulse 108, temperature 103°. Patient slept during the day, and feels more comfortable. The mammæ were small, without tenderness, and contained but little lacteal secretion, although they had been suckled and drawn with breast pumps. She suffered severe pain in the right hip joint when lying on the right side. No extension of erysipelas since morning; used the vaginal injections, and continued treatment.

February 16, 9 A. M., pulse 96, temperature 100°. Patient had a better night, tongue cleaning, relishes food, erysipelas subsiding, inflammatory blush and hardness much less. On passing the apex of index finger into anus, a small quantity of bloody pus was discharged. The sphincter contracted over the finger, and gas passed with little pain. There was no occasion to use the rectal tube—a No. 16 English gum catheter—which was directed to be used when necessary. I removed the middle or third perineal suture. There was no pus, and the wound was closed. The vaginal injections and general treatment were continued; the room to be still disinfected two or three times a day with freshly parched coffee beans. The wound, at the evening visit, was more sensitive than heretofore.

February 17, 9 A. M., pulse 90, temperature, 98°, the erysipelatous blush receding rapidly. Removed second and fourth sutures, the wound still looking in good condition. Suspended the quinine on account of quininism, continued the iron, morphia. and concentrated nourishment, but allowed no solid food.

5 P. M. pulse 112, temperature 102½°, some thirst. She to-day complained of more pain when lying on the left side, the position she decidedly preferred because most comfortable. Probably the pressure and unavoidable moisture of the clothing, at times, from discharges, may have acted as an irritant and favored the extension of the erysipelatous inflammation to the loins and spine, which explained the change in pulse and temperature. After using the carbolized hot water and glycerine vaginal injections, she was directed to lie on the right side, and the entire old and new field of erysipelas and surrounding healthy skin were painted with several coats of collodion. The muriated tincture of iron was given every two hours, three grain capsules bisulphate of quinine and one fourth grain morphia every six hours.

February 18, 9 A. M., pulse 112, temperature 99½°; 6 P. M. pulse 116, temperatute 102¼°. No extension of the disease, tongue moist and clean. There was a copious non-sanguinolent uterine discharge to-day. The first and fifth perineal sutures were removed. The usual vaginal injections were administered, the diseased surface painted with collodion, and the general treatment continued.

February 19, 9 A. M., pulse 100, temperature 99¾°. She had a good night, there is a slight discharge of pus along the line of the perineal wound; the anus is more easily penetrated, no extension of erysipelas, the blush paler, the left nates is still swollen, the tumefaction reaching the raphe or line of the wound, but there is absence of pain. Treatment continued.

6 P. M. pulse 116, temperature 102¾°. Since the morning visit the erysipelas has extended across the line of perineal wound, over the sacrum and part of the right natis. The entire surface involved was thoroughly painted with the collodion, also the healthy skin on the vulva as a protection from vaginal excretions. Ordered muriated tincture of iron, twenty-four drops every two hours, and the following mixture:

℞ Bisulphate of Quinine - - - - - grs. iij.
Sulphate of Morphia - - - - - gr. ¼.
Whiskey - - - - - - - ℥ ss.

M. S. For one dose. To be repeated every six hours.

As nourishment she takes, every twenty-four hours, one pint of cream, two teaspoonfuls of Liebig's extract beef powder, and chicken soup made from the meat and bones, the skin being first removed.

February 20, 9 A. M., pulse 102, temperature 100¼°, She had a bad night, vomited the iron, and suffered from gaseous distension of the stomach and bowels, and collicky pains which were relieved with bicarbonate of soda and essence of peppermint. An alvine evacuation was threatened, and the rectum was moderately distended with feces. There was still some oozing of pus from the perineal wound, and non-union of the skin, the erysipelatous inflammation had destroyed the plastic material. The parts were not separated to explore the extent of the solution of continuity. Suspended the iron, and ordered the quinine and morphia every six hours, and diet as before. The carbolized hot water vaginal injections, followed by the carbolized glycerine, were rigidly used, and collodion painted liberally over the diseased skin.

6 P. M., pulse, 116 temperature 103°. No nausea or vomiting to-day, no gas or effort to have an evacuation; complains of soreness of hip and thigh; the surface red, but no hardness or elevation of the skin; discharge from the vagina slight. Ordered six grains bisulphate quinine every six hours until she was thoroughly quininized, morphia as before, and the entire red surface painted with collodion.

February 21, 10 A. M., pulse 86, temperature 98½°. She had a comfortable night, good, quiet sleep, and healthy free perspiration; the tongue is moist and clean, erysipelatious blush subsiding rapidly. Removed a portion of the collodion glazing, skin healthy, some tenderness and

redness over right hip and thigh, due to lying in one position. Ordered the red surface painted with collodion for protection from pressure and moisture. To secure more perfect coaptation of the perineal wound—length three-fourths inch, depth one-half inch—and facilitate, if possible, union by adhesion or granulation, I applied over the nates two strips of rubber adhesive plaster, one and a half inches wide by eighteen inches long, the center of the strips corresponding to the wound. The cleft of the nates was drawn moderately tight to hold the surfaces of the wound in apposition. After the plaster was adjusted the patient expressed a feeling of relief and comfort. General and local treatment continued.

6 P. M., pulse 101, temperature 101¾°. She had a good day, slept quietly a great part of the time, food relished, no gas or pain in the bowels, no discharge from the wound since the rubber plaster was applied. The patient again spoke of the great comfort from the support of the plaster.

February 22, 10 A. M., pulse 96, temperature 99½°; 6 P.M., pulse 100, temperature 102°. No thirst to-day, slept soundly, no secretion from the wound, rubber plaster firmly adherent, some gas passed *per rectum*, no complaint except fatigue and pain in the right hip-joint. Free secretion of urine, which is now limpid and almost natural in color. During the erysipelas it was high colored and turbid. The secretion has, throughout the treatment, been copious. The catheter, for two days past, has been used every three or four hours; previous to this, every six hours. The free secretions of the skin and kidneys seem to act as safety-valves, and compensate for the lockup of the bowels. Ordered three grains bisulphate quinine and one-fourth grain morphia every six hours, and the under surface of right hip and thigh painted with collodion. All symptoms of erysipelas having disappeared, I could now distinctly feel the cicatrix the entire length of the wound in the recto-vaginal septum, indicating union of the parts lacerated, as noted above.

February 23, 10 A.M., pulse 100, temperature 101°. Despite the elevation of temperature, the patient feels comfortable. There is no abnormal heat of the vagina, no gas, no impaction of excrement in the rectum, and no oozing of any secretion from the perineal wound. The rubber plaster still adheres well and does not in the least interfere with local manipulation, and injections. The catheter has been used less frequently the past twenty-four hours. The quinine was suspended, morphia given as usual, and concentrated nourishment taken at regular intervals.

February 24, 10 A.M., pulse 102, temperature 101°; 6 P.M., pulse 108, temperature 102°. No change worthy of note; treatment continued and collodion painted over all red surfaces.

February 25, 10 A. M., pulse 96, temperature 101°; 6 P. M., pulse 102, temperature 101½°. Profuse perspiration last night; had a comfortable day, excepting uneasiness for a short time from gas. Permission was given to turn and change position at pleasure. When turned on the left side, the full extent of the surface affected by erysipelas was apparent. The inflammation extended

over the left nates, hip, thigh, loin, and left side of the abdomen up to a line parallel with the umbilicus, and inwards on the cleft of the left nates to the perineal wound and lower half of left labium majus. The fifth day after the advent of the disease it extended across the median line, over the right nates. hip, thigh, back and abdomen above the height of the umbilicus. To-day all redness, with the exception of a small space over the right trocanter major—due to pressure—has faded, and tenderness on pressure has ceased. The vagina and wound are free from discharge. Treatment continued.

February 26, 10 A. M., pulse 98, temperature 98½°; 6 P. M., pulse 120, temperature 102¾°. Cathether has only been used twice in eighteen hours. Ordered six-grain doses of bisulphate quinine to be given to-morrow forenoon at 8 and 10 A. M. and 12 M. At 9 P. M. was summoned in haste, and on arrival found that the patient had been awakened from a sound sleep by severe griping pains, followed by a loose evacuation, which had passed upwards over the vulva and back between the cleft of the nates—the direction being due to the pressure of the rubber adhesive straps. A thorough examination showed union of the sphincters and upper part of the perineum, the skin and cellular tissue of the intervening space had not united; the exposed surfaces were clean, granulations healthy and no pus, the vaginal cicatrix was firm, and the vagina devoid of feces. The parts were drawn well together by new rubber adhesive straps and one fourth grain more of morphia given. The fever of the evening was subsiding.

February 27 and 28 pulse ranged from 90 to 98, and the temperature from 98½° to 100°; no change in treatment.

March 1 to 3 inclusive, pulse 84 to 90, temperature 98° to 99°. Continued the quinine and gave half to one-fourth grain morphia at night, omitting it during the day. The vaginal injections were given twice daily. At the morning and evening visits enemeta of warm soapsuds were administered, each of which removed a portion of the accumulated contents from the rectum.

March 4, pulse 90, temperature 98°. She had a free natural alvine discharge this morning, which completely unloaded the rectum. The knees were unbound and the four vaginal sutures were removed. The union of the recto-vaginal septum was perfect, and the internal sphincter contracted firmly around the finger. A fissure in the perineum three-fourths of an inch long and one-fourth inch in depth is the only remnant of the extensive laceration. The patient declined to have sutures admitted to make the operation not only successful but complete. Applied new rubber plaster across the buttocks to compress the perineum until the parts fully contract, and ordered the nurse to give, morning and evening, a hot-water vaginal injection—no further restriction in diet.

March 7, pulse 88, temperature 98°. She has sat up a short time each of the past three days. She has numbness of the lower extremities and the hip-joints and spine are stiff from lying so long in one position. For three days she has taken daily six grains of quinine, but no morphia at night. She has a good

relish for food, and has gained strength rapidly. To promote further granulation in the small fissure, I ordered the following:

℞ Iodoform - - - - - - 3 ss.
Coca Butter - - - - - - grs. xi.
M. Ft. tablets, No. viij.
S. Insert in fissure daily and retain if necessary with T compress.

March 12, pulse 84, temperature 99°, more strength in hip joints, but is unable to walk yet without support. She has a daily alvine evacuation, and says she now has as good control over the bowels, and sphincters as she ever had. Perineal wound smaller. On the 8th suspended quinine and ordered syrup hematic hypophosphites, (P. D. & Co.) one teaspoonful three times a day. She eats and digests any kind of food, but prefers plain, substantial edibles, such as beefsteak, oysters, corn bread, etc.

March 15, pulse (sitting up) is 90, temperature 99°, she is able to walk alone. Rubber adhesive straps and other treatment continued.

March 21, pulse, sitting up, 90, temperature, 99°, general condition, good, the surfaces of fissure tender from application of stick nitrate of silver, two days ago and apparently in good condition to further granulate; applied a long strip of rubber plaster over the buttocks, passing over center of the pereneum. The plaster does not interfere with the regular evacuation of the bowel or bladder, or sitting up and walking about the house. Menstruation came on yesterday, the flow was limited, a pledget of absorbent cotton was introduced between the labia and inferior commissure to protect the fissure from the secretions of the uterus and vagina.

March 22, 12 M., pulse, 96, temperature, 101°, tongue white and furred, no appetite, skin dry and hot. At 2 A. M. she awoke with severe pain in the left loin, and great tenderness of right ovary. Treatment,

℞ Morphiæ Sulphat. - - - - - grs. ij
Ipecac. Pulv: - - - - - - grs. j
Extracti Belladonnæ - - - - - grs. j
M. Ft. capsules no. viij.
S. One capsule every two hours until pain is relieved. Apply over the abdomen hot flannel fomentations, sprinkled with turpentine.

℞ Bisulphate Quinine - - - - - 3ss
Ft. capsulæ no. xij.
S. Two capsules every two hours until three doses are taken daily. Vichy water (artificial) as a beverage *ad libitum.*

March 23, 12 M., pulse 82, temperature 100°; one anodyne capsule and the hot fomentations relieved the pain.

March 25, 12 M., pulse 90, temperature 100°; she has been excited to-day by departure of her husband on business; she feels well, appetite returning, no thirst, and sleeps well. The fissure looks well, and has almost filled up, least depth one-eighth inch, greatest one-fourth inch. Ordered five grains bisul-

phate of quinine at 9 and 11 A. M. for three days, and the syrup of hematic hypophosphites to be resumed at meal time.

March 31, pulse and temperature normal, appetite is good, she is able to ride out, the vagina is contracted and muscles firm, womb in natural position, no discharge, the bowels act daily without medicine, the anal sphincters are perfectly restored. She suffers no pain and feels as well as she ever did, saving weakness from confinement to the house and want of accustomed exercise. Ordered syrup of hematic hypophosphites to be continued three times a day in teaspoonful doses, at meal time, good substantial nourishment, and daily out-door exercise. Patient discharged cured.

To myself this complicated case was an interesting one, and of sufficient importance to very briefly direct attention to some salient points. Traumatic erysipelas, under the most favorable circumstances, is, in recent wounds—accidental or surgical—a dangerous complication, occurring the fourth day after the operation, before the plastic material had become organized, it was exceedingly fortunate that the inflammation destroyed only a small portion of that which united the perineal wound. There was entire freedom of the vagina, uterus, and peritoneum from any symptoms of erysipelatous traumatism. Where post partum erysipelas occurs, the uterus with peritoneum is usually first attacked, and the disease often ends fatally. In this case there was every reason to apprehend a failure of the operation and great danger to the life of the patient. It is fair to infer that the scrupulous care that was taken to ensure local disinfection was entitled to much credit for the success.

I am disposed to believe that the persistent use, first of the hot water injections, and of the carbolized hot water injections followed by the carbolized glycerine lotion in sufficient quantity to cover and protect the cervix, vagina, and entire tract of the wound, did much to preserve these organs and tissues from invasion of the disease. The simple hot water was, in my judgment, the chief preservative. Hot water is a great antiseptic remedy; it soothes irritation, it allays and prevents inflammation, it stimulates the capilliaries to activity and arrests inflammatory effusions, it acts as an astringent and prevents the absorption of septic poison or essence of decomposed fluids, and it destroys germinal vitality. It is highly probable that hot water will, in itself, accomplish most that is claimed for the antiseptics largely diluted with water.

The question may be asked, do we not attribute many of the good results obtained in solutions, locally applied, to the medicine, and rob the water of its proper meed of praise? Is the profession generally yet prepared to give water —at temperatures varying from ice to steam—its proper rank as a powerful therapeutic agent, when intelligently used, and equally as great a power for evil when used unadvisedly and indiscriminately?

The profession almost uniformly make local applications in erysipelatous inflammation—traumatic or idiopathic—some of them mild to soothe and allay irritation, others to prevent the extension of, or to arrest the inflammation. Exactly how far, or in what way, local remedies arrest, shorten the duration

of, and hasten a cure of the disease, has not been positively determined. Suffice it to say, such remedies are used, and we have faith in their efficacy in some way.

In this case, the desideratum was, what to use. Under the circumstances, soothing remedies, lotions, hot foments, poultices, &c., were out of the question; the destructive agents—nitrate of silver, iodine, &c., could not be used. In this dilemma collodion was selected; it was used unsparingly, and met the emergency. It formed an impervious coating over the inflamed surface, excluding air and moisture; in drying, it contracted and unloaded the capillary vessels, diminished the redness and tumefaction of the skin, and prevented the formation of bullæ. It allayed cutaneous pain and irritation, it shielded the skin from destruction, and prevented the intolerable heat which would have ensued by lying constantly on the inflamed cuticle. It was so transparent that the local condition was always visible and the patient was not annoyed with redressing more than once in one to three days. If it cracked, a camel's-hair brush, armed with collodion soon repaired the breach, and every third or fourth day, when it became detached in mass, it was removed and renewed. It certainly did shorten the duration of erysipelatous redness and swelling. In my next case of erysipelas, I will substitute flexible collodion—if not quite so adhesive and transparent, it will be more pliant and pleasant. To any of my former students, who may read this article, I confidently recommend this remedy, in preference to any other, as a local application in erysipelas.

In all future operations of this class, I shall use the long strips of rubber adhesive plaster, and will apply them as soon as the sutures are adjusted. I feel satisfied, from my observation in this case, that the straps will relieve the tension on the perineal sutures, prevent disturbance of coaptation and add much to the comfort of the patient.

Eminent gynæcologists are divided in opinion as to the advisability of, or preference for, a primary or secondary operation, having in view, on the one hand, the safety of the mother; on the other, the success or failure of the operation. Some advise a primary proceeding as soon as possible after the accident; others advise it where the perineum or perineum and anal sphincters are ruptured: but decline to operate when the recto-vaginal wall is, to any considerable extent, implicated. Others advise waiting a few days until uterine hemorrhage and discharges have ceased; while others—the minority—advise postponement of all operative interference until the patient has recovered entirely from the effects of parturition.

It is not my province or purpose to criticize the matured opinions of others, or attempt by argument to show the futility of objections to the primary operation. It would be useless, at this day, to discuss and contrast the advantages and disadvantages of primary and secondary operations. I give my opinion for what it is worth. While I cannot admit of any serious danger to the patient from an immediate operation—if it fails the patient looses nothing—I can see many complications and perplexities from delay for a secondary operation,

viz.: long confinement to the recumbent position, inability to stand erect or walk without distress or pain, eventually prolapsus or procidentia uteri, irritation of the bladder, vesical or rectal hernia, or both, involuntary discharges of feces and gas, exclusion from society, mental agony and utter disgust with self and all earthly things.

From my own observation in this complicated case, I am, under all circumstances, a decided advocate for the primary operation irrespective of the extent of laceration of the recto-vaginal septum; and where the accoucher is unskilful, would advise summoning an expert operator; a few hours delay would not materially militate against success. If there is hemorrhage, use ergotin by the mouth or hypodermically, hot water injections, digital titillation, plug, etc.; if the patient is prostrated from loss of blood, sustain strength by alcoholic stimulants in moderation, fluid extract or wine, or better still, glycerole of coca—the latter a palatable and efficient preparation manufactured by J. A. Flexner of Louisville—administered in full doses, hot sweet milk, with the bicarbonate of soda, or aromatic spirits of ammonia if the stomach is acid. Then anæsthetize the patient, and take time to perform the operation well and thoroughly, first preventing the flow of blood by sponges pressed high up in the vagina and held if necessary with forceps or wire, then clipping the ragged edges, and cleansing effectually with hot water. Should I be called to see a case similar to the present one, after adjusting and clipping off the ends of the sutures I would dry the vagina and perineal surfaces with soft lint or absorbent cotton, and paint the entire track of the wound with flexible collodion, keep the vagina coated with carbolized glycerine, and personally supervise all local manipulations.

If a trained nurse could not be procured to introduce the catheter as often as necessary, to prevent any flow or dribbling of urine over the wound, or if the bladder became irritable, I would introduce a self-retaining catheter, with several feet of gum tubing attached to the open end to convey the urine as fast as secreted into the chamber. Keep the patient constantly on one or the other side, and use the catheter and all vaginal injections without change of position. It is premised that the patient will use concentrated food; the bowels to be kept locked up with opiates, and rectal gas removed by the introduction of a large catheter; if the gas is very annoying, introduce a short piece of gum tubing or end of a catheter and let it remain permanently to give free exit to, and prevent distention of, the rectum from accumulated gas.