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RUPTURE OF THE FEMALE PERINEUM.

BY

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SOME PRACTICAL POINTS IN CONNECTION WITH RUPTURE OF THE FEMALE PERINEUM.[1]

By Wm. Dunnett Spanton, F.R.C.S.E.

My subject may be deemed somewhat trite, for who has not come across a ruptured perineum? But there are some aspects of this condition which may usefully be brought up for our consideration and discussion, and it is because I think some of these views have not been sufficiently enforced that I venture to take up your time with such an old theme.

For a long time the real nature of the perineum as a support was not at all clearly defined, and most of the older descriptions, and the diagrams of comparatively recent years, have led to very erroneous impressions; and it was not until the anatomy of the perineal body was more accurately described that any correct views were found to prevail with regard to the conditions caused by its rupture, and the proper method of repair.

If we keep clearly in our minds that the perineum is not merely a septum of skin, but a wedge of solid tissue supporting the posterior vaginal wall on one side, and the rectal wall on the other—a sort of buttress to both—it will be apparent that the early operations for its relief, when torn through, almost invariably failed, because they were directed rather to restoration of skin than of the deeper structures of this solid wedge-like perineal body.

In dealing with this subject we may, in fact, disregard the mere tearing of the skin which almost invariably occurs, to some extent, in first labours; because it heals readily without interference: but when sufficient force is used to lead to any degree of laceration of the deeper tissues, even without a break of surface, true rupture takes place, to which it is the object of these remarks to refer.

Laceration may, and often does occur in the course of ordinary natural labour, especially if the child be large and delivery of the shoulders rapid, and it is perhaps even more frequent in breech presentations.

But more often it is caused by the use of the forceps before the soft parts are sufficiently dilated, and delivery being effected too rapidly. It may occur in the practice of

[1] Paper read before the Staffordshire Branch of the British Medical Association.

the best accoucheurs, and in many instances it is quite inevitable, unless lateral incisions are made to enlarge the outlet—a practice only to be deprecated.

Every practitioner is familiar with the unhappy results which follow ordinary rupture when neglected. It is one of the most frequent causes of prolapse of the uterus, leading to uterine congestion, and all its usual train of symptoms.

If I were to record all the miseries some authors describe as consequent upon it, I might shortly summarize them as an index of gynæcology. Dr. Matthews Duncan says, "when the whole sphincter is destroyed, the woman's condition is truly pitiable. She has no chance of ease or comfort, even temporarily, except from a successful operation for the restoration of the perineum."

Cazeaux and Tarnier point out that cases of hæmorrhage, supposed to be uterine, have been due to rupture of the perineum, which has not been carefully noted, when the tear has extended more deeply on the internal surface than through the skin.

Although it may be true that small lacerations usually heal of themselves, we are hardly warranted in taking it for granted that everyone will do so, and it is safer in the light of the evils which may accrue from neglect of even a slight rent to get rid of a raw absorbent surface in such a situation as soon as practicable.

At this point we come to a diversity of opinion, with which I do not intend to trouble you, as in a matter of this kind it is just as well to give one's own. The more I see of such cases (and they are more common since forceps have been so generally employed) the more am I convinced that the proper treatment is to deal with the injury immediately. I cannot too strongly impress on those who have not perhaps considered the subject of a torn perineum of much consequence, that it is the duty of the surgeon to see that it is repaired as soon as possible, for his own reputation's sake, as well as for his patient's welfare.

This, of course, implies that in all those cases demanding suturing, it should be done as a part of the lying-in toilet; and it is well to have in one's obstetric case some good, thoroughly clean, curved needles and silk, or silkworm gut, ready for use. Those usually found in an ordinary pocket case are by no means aseptic, and ought to be avoided, if possible, in the case of a parturient woman, who is usually very susceptible to any septic influences.

It may seem trivial, perhaps impertinent, to refer to the mode of suturing a recently torn perineum, but I do so

because I have seen many which have been "sewn up" where a mere bridge has resulted, or a recto-vaginal fistula.

The surfaces should be well cleaned before anything is done, some cocaine solution freely applied, and the sutures inserted at intervals of not more than one-third of an inch deeply into the substance of the perineal body, but not through the rectal mucous surface, and they should not be drawn too tight.

A perineum which has been overstretched and has given way is sure to be more or less œdematous and contused afterwards; and if the sutures are tight they will soon cut, and cause much pain. No dressing is needed. Union generally takes place rapidly, but it is well to leave the sutures in about a week, and, if the vagina needs syringing, the nurse should be cautioned not to touch the posterior vaginal wall. If the suturing is done immediately after the labour is over, the patient very rarely makes any demur; a stitch or two means a mere nothing *then*, but if it is deferred, few women would consent to its being done without an anæsthetic; with the further drawback of having an irritating lochial discharge passing over it and interfering with union.

The discharge immediately following delivery is unirritating, and does not at all endanger rapid union.

Shakespeare's dictum applies to this as to so many things mundane, "an 'twere done, 'twere well done quickly." As a typical instance of what may occur in a case of laceration of the perineum which has been left to itself, I will mention that of a patient I was asked to see some time ago. She had been delivered of her first child three days before, after a protracted labour. At the time I saw her she was drifting into a septicæmic state with a temperature of nearly 105°, dry tongue, pulse 130, fœtid diarrhœa and tympanites. There was a rent through the perineal body extending into the rectum more than three inches. The vagina was full of fœtid lochia and fæces, and the bladder distended with three days urine. We had the bladder relieved, the vagina properly irrigated, and so on; but it was many months before the patient was in a fit state for a reparative operation. When I did operate in the way I usually adopt the result was entirely successful, and she is now perfectly sound and well.

The interest lies, however, in the fact that an action was entered against the surgeon for damages, and the counsel for the claimant stated fairly enough that the ground of action lay in the neglect to repair the injury at the time of its occurrence, and not the damage itself, as that was an

accident which might take place in the most skilful hands. The action resulted in the payment of the sum claimed by the patient, under the advice of the medical man's solicitor.

The legal point is perfectly clear, that when in the ordinary course of treating a patient a mishap does occur, the surgeon will not be held liable provided he takes the necessary steps to put it right; but, on the other hand, the neglect to do this, whether from oversight or from a sense that it is unnecessary, renders him liable for any after-trouble, loss of time, and so on, to which the patient may be in consequence subjected.

Some American authors would extend this responsibility to the condition of the cervix uteri also, but I hold the opinion that, however much such lacerations may lead to evil consequences afterwards, we are not called upon to examine the condition of a woman's cervix unless there is some special reason for it. A clean tear in the cervix will probably heal up just as one in the fourchette does, and if anything has to be done, it would be better when the uterus is in a quiet state. A turgid, bruised cervix is not in a condition favourable for any surgical proceeding such as suture. I do not find in the text books on this subject much reference, and in the majority of them no reference whatever, to the moral obligations involved in it; and I desire especially to emphasize this with reference more particularly to its medical and legal aspect; and, at the same time, to remind my professional brethren that it is incumbent upon us all in the course of our duty in delivering a patient from one danger to see that no other befalls her through any want of care or circumspection on our part.

On the other hand, many of the most lamentable instances occur where no one has perhaps been present at the birth of a child, or a midwife has been in attendance, and in connection with this an interesting question will arise, whether it is not in the latter case the bounden duty of a midwife to summon surgical assistance at once, just as it is incumbent on the surgeon to act when present. Under no circumstances, I apprehend, ought a midwife to be permitted to repair a damaged perineum; but, if I am right in my view, it is equally incumbent on her to see that it is done without delay.

If I were to attempt to describe the operations which have been practised for the cure of ruptured perineum of longer standing, I fear your patience would be exhausted long before I reached the end, for as Treves says "There is no form of suture designed by man which has not been

tried on the female perineum." It is just one of those instances in which the ingenuity of the surgeon proves so valuable in enabling him to deal with each case individually. They differ so much in various ways that any one method cannot possibly apply to all the conditions we meet with.

I do not intend to enter now into the question of operation for prolapse of the uterus ; that would form a sufficient subject for a paper by itself, but only so far as it is included in repair of a ruptured perineum.

You will find described by gynæcologists some most elaborate methods of restoring the perineum ; one may say of them *quot homines, tot operationes.* They resolve themselves, however, very much into three classes.

1st. Those described by the older authors, of which I may take that of Baker-Brown as a good type (fig. 1), in which a bare surface is made by paring away of mucous membrane, and the raw surfaces are kept in apposition until healing takes place. In this form no attempt was made to restore the perineal body to its original form.

2nd. Those when no tissue is removed, but flaps are made, pushed forward and backwards, and the sides of the vulva brought up together, in this way restoring the parts as nearly as possible to their original condition, and making the line of the cicatrix longitudinal instead of transverse.

3rd. More complicated procedures, such as Freund's, of which flaps of irregular shape are made with a view to a more perfect adaptation.

Among the first class we still find surgeons who denude and remove mucous tissue, but they mitigate the evils of the old method by using deep-buried sutures in layers and so approximating the flaps as to ensure solidity. But even in the hands of Baker-Brown and Simpson the method seems to have often failed, wholly or partially, and it has now fallen largely into disuse. Nevertheless, it is one which most of us have made use of in years gone by, and often the results were good, though by no means uniformly so. From this mode of operation which failed sometimes because so much tissue was removed as to leave no sufficient support even when the parts were well approximated, and nothing but a sort of bridge of skin resulted, it seemed only a natural transition to leave the detached tissue instead of cutting it away. It is now several years since I adopted this plan, and since that period the results have been most gratifying. Formerly, the dissecting off of the flaps was done with a knife, but it is found that scissors are more expeditious and simple. The resulting perineum is far more satisfactory, and a failure is very rare. It applies

with even more force when there is an extensive tear in the septum, as in such cases the structures are often greatly thinned with cicatricial tissue, and by no means favourable for healing.

The mode of operation I now adopt (which has been a sort of gradual evolution) is as follows :

The patient is carefully prepared several days beforehand by having the bowels well cleared, and an enema administered a few hours previously, not just before the operation. The surface is shaved and well cleansed with carbolic soap, and then chloroform. The best time is just following a menstrual period ; and the patient is kept in bed a day or two beforehand. Placed in the lithotomy position the nates are gently drawn asunder and the exact extent of denudation which will be necessary is estimated.

This will vary according to the extent of the tear, the thickness of surrounding tissues, and very much on the openness of the vaginal outlet. It is a mistake to disturb too much mucous membrane, and, *a fortiori*, too much skin to make flaps ; but if too little be taken the parts will not be sufficiently braced up.

Usually the line between the labia minora and majora is a good guide, and a rounded incision is made across the septum formed by the remains of the perineum and extending on each side far enough forward to form a broad surface, of which the sides are to be brought into apposition (fig. 2). The flap is dissected up by a so-called splitting process keeping as nearly as may be equidistant from vagina and rectum. This often requires care to avoid opening one or the other, and is facilitated by passing the finger, or fingers, into the rectum. This is better avoided if possible as it is likely to contaminate the wound, and is not always necessary.

The flap of vaginal mucous membrane and skin from the sides of the vagina is held forward and brought together by a tenaculum or suture, and held there until the deep sutures have been inserted (fig. 3). Sometimes bleeding is rather free, but torsion or a hot sponge with pressure will generally stop it. If not, I always prefer to ligature any vessels with fine catgut rather than leave any oozing to occur afterwards, because it is so important to secure complete and accurate adaptation of the sides of the wound. A full-curved needle is then passed from one side of the raw surface to the other, commencing about one-third of an inch outside the skin margin, and keeping it buried in the tissues so as to emerge on the opposite side at a corresponding point. This is then threaded with silkworm gut (previously softened by soaking), and the needle

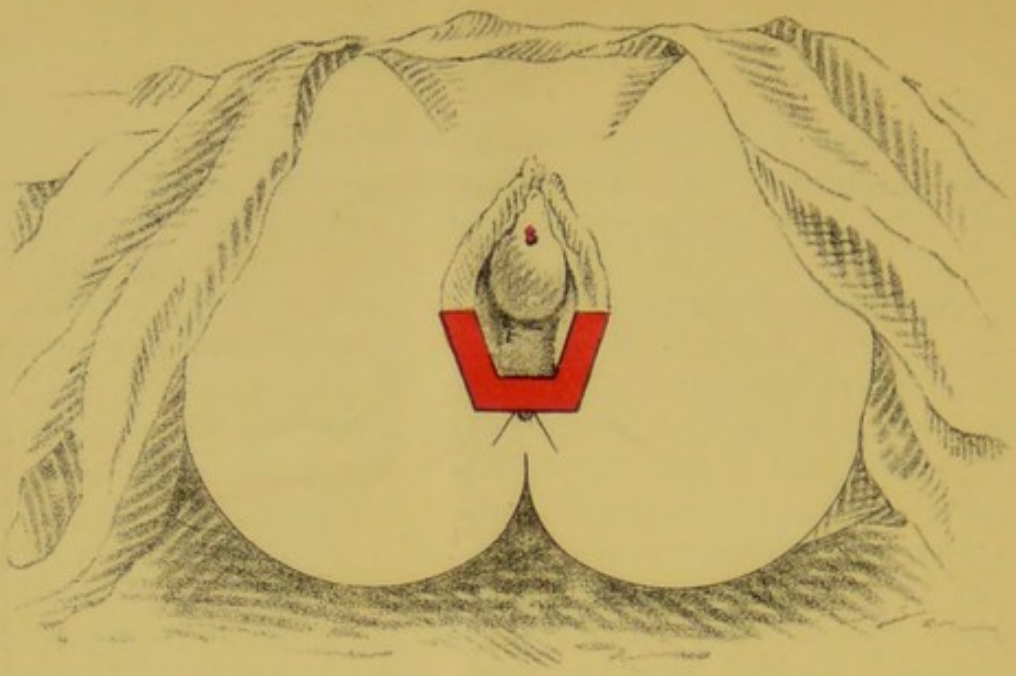

FIG. I.

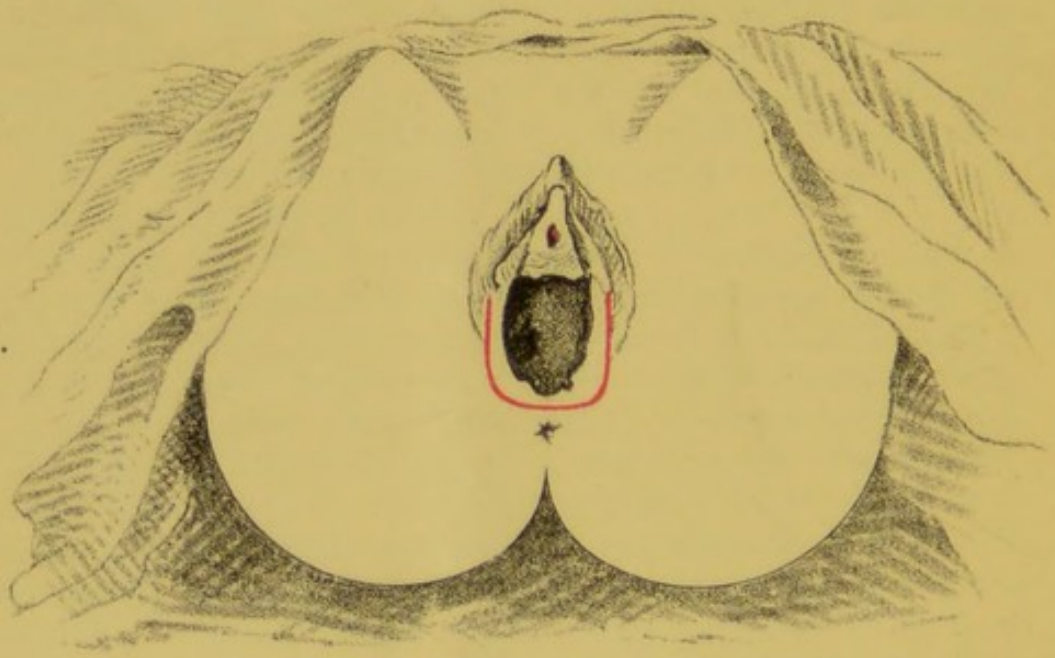

FIG. II.

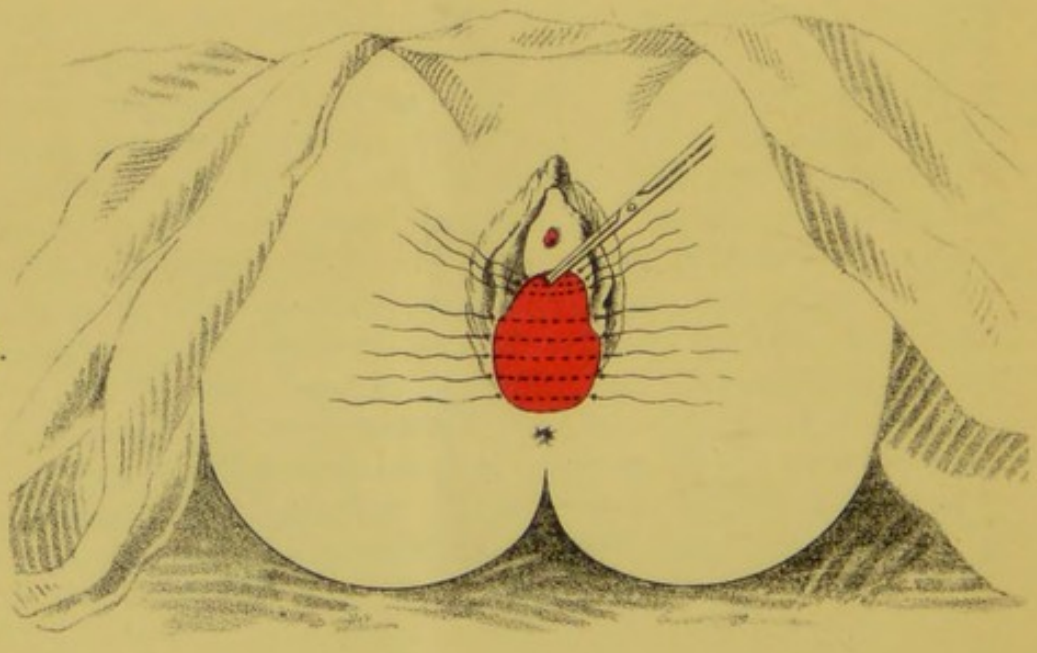

FIG. III.

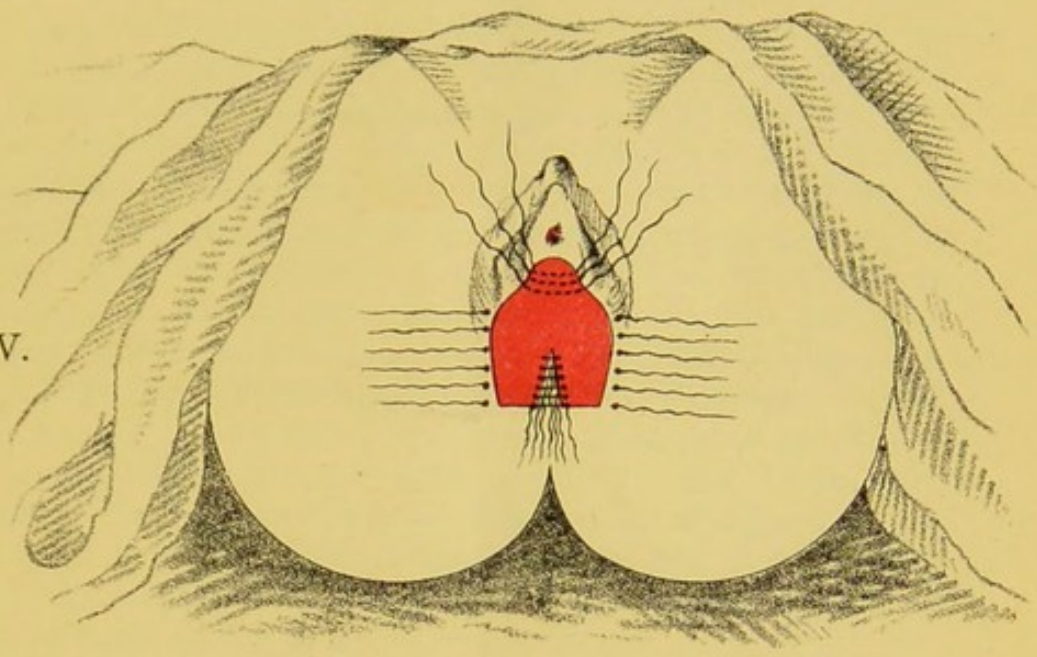

FIG. IV.

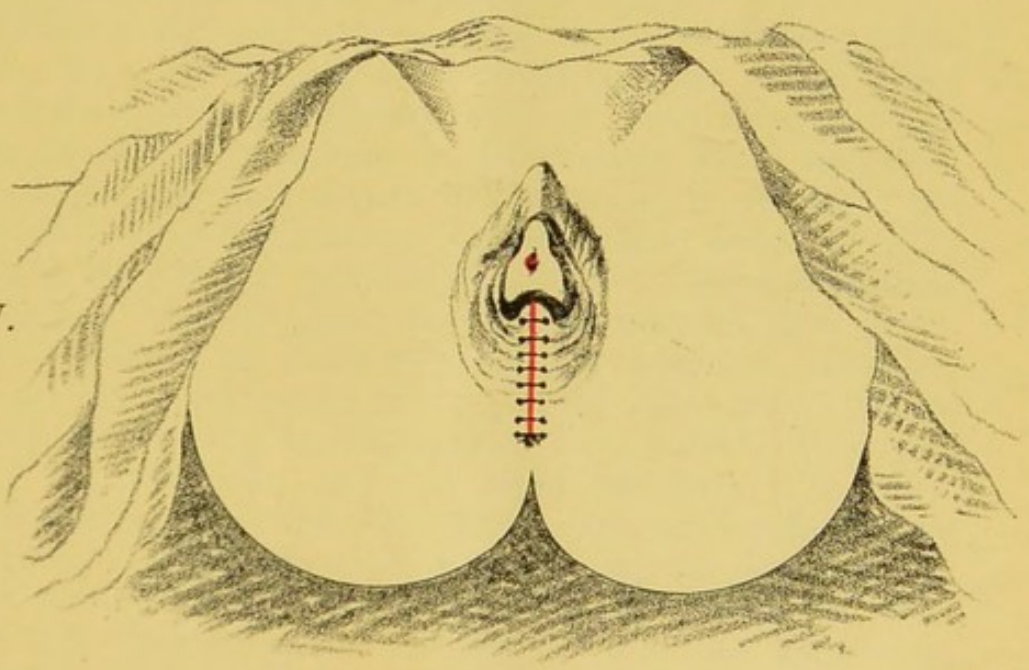

FIG. V.

withdrawn. As many sutures as may seem needed are passed in this way, usually about ⅜ inch apart, or, in a thin person, less than that, and these are then drawn up, not too tightly and secured. Then some catgut sutures are placed in the anterior vaginal margin, usually two or three, and cut off short. This I find gives comfort to the patient by doing away with the projecting point; which otherwise is left, and is often a source of great discomfort by coming in contact with the catheter. It also has the advantage of checking any oozing into the vagina. I do not generally use any other superficial sutures, but sometimes in very stout persons it is well to do so, and place the deep ones a little further apart. As a rule I employ no dressing of any kind; but occasionally dust on some iodoform and boric acid powder. Only if there is a tendency to bleeding is a pad of any kind applied. Before being put to bed it is well to empty the bladder and press the parts gently together so as to leave them as dry as possible.

Afterwards if there is much pain, a suppository of morphia is given, but not otherwise; and in those cases I shall refer to presently—when the rectum is sutured—I use a suppository of iodoform and cocaine instead. Scrupulous cleanliness must be observed afterwards, and this is best done by gentle syringing with a small syringe so as to touch the parts as little as possible.

Failure is rare, and even in those instances where partial giving way takes place, it is surprising how firmly they consolidate after granulating up. I have done a very large number of operations in this manner, but it seems to me needless to give details of them. It is not usual to have any rise of temperature, but if it does occur, it may indicate the need for removal of a suture; or washing out the vagina to clear away any septic material, but more often it calls for the administration of an aperient. Usually I wait for some complaint of rectal discomfort before having the bowels moved, generally about the 4th or 5th day; but when the tear has been complete it is very important to see that the fæces are softened before evacuation. This can best be done by the injection of small quantities of warm water or oil, letting the fine nozzle be moved about a little so that the fluid may penetrate and break up the mass, otherwise the rectal sutures may give way. I have known nurses who have given a large ordinary enema under these circumstances with the aforesaid result. The sutures are removed about the 9th or 10th day, or before if they are too tense. Otherwise the longer they remain, if unirritating, the better.

Those at the anterior margin usually need no attention, if of catgut. Unless there is any moisture about the vagina I do not usually irrigate it; but when it has to be done, weak carbolic lotion is best used with a small nozzle, such as that of a glass female or soft rubber catheter, and very gently.

The urine is drawn at intervals according to the feeling of the patient. Some women can retain urine with comfort many hours, and do so habitually, so there is no reason why they should be troubled unduly often. Others need it perhaps every five or six hours, and if the catheter causes much pain or irritation it is best to allow the patient to micturate lying towards the face, and gently irrigate with warm water immediately.

After the first forty-eight hours I do not think any harm ever results from this. The most frequent and troublesome complication is urethritis or cystitis, and this is a strong reason for dispensing with the use of the catheter as early as possible. So long as the patient keeps her legs fairly well together, I do not think the position of lying matters at all; the prone position tends to ward off bladder trouble, and allow of a more free exit of discharge if there should be any. The patient should be kept in bed at least three weeks.

I have here described the procedure of a simple case not involving the rectum, but where this exists it is necessary to do something further in order to securely close up the rectal opening, and if this be carefully carried out the results seem to be almost invariably as good as in the more simple cases. Here I begin by making the flap as already described forwards; then commencing at the anterior margin of the anal opening a smaller similar flap backwards which is to cover in the rent in the rectum (fig. 4). This flap is turned back and the margin pared so as to leave edges which will unite. I then pass with a sharply-curved thin Hagedorn needle a fine catgut suture, first through one side, and then the opposite, from the raw surface through into the rectum, leaving the ends hanging out. As many as may be necessary are inserted in the same way, about $\frac{1}{6}$ inch apart, and the last one at the anal margin being taken more deeply, so as to bring the sphincter well round at the anal orifice. These sutures are then tied from above downwards, each knot being left in the rectum and the ends cut off short. I often use a continuous suture of catgut where the rent is large, and sometimes a second buried one after the plan of Martin, of Berlin, if the tissues are very thick and lax. It is always needful to exercise some care to invert the edges towards the

rectum so that as broad a raw surface as possible is brought into close opposition. And it is for this reason I much prefer sutures either continuous or tied within the rectum, rather than tied, as some advise, externally in the perineal wound. Sometimes the knots of the latter do not become absorbed, and keep up irritation which might in this way lead to an unsuccessful result. When this is done there is an extended raw surface reaching backwards over the anus behind, and with the puckered rounded flap reaching up the vagina in front. This large raw surface is then brought together over the rectal sutures, just as I described for the simpler operation, and the wound closed in the same way (fig. 5). I find it useful at the finish to put an additional suture at the point which is to represent the posterior edge of the new perineum, for it helps to secure a rounded surface when all heals up, and I used to find patients complain of the point left before I began to insert this suture. The results of this operation are far more satisfactory than when the sides are merely approximated by the double flap, and in two patients on whom I operated lately, where the rent into the rectum measured three and a half and three inches respectively, the result was perfect in each instance, although there was very little normal tissue left adjoining it. Some of the partial failures arise from getting up too soon. After the first action of the bowels I like to have them moved every day. This obviates any stretching of the recto-vaginal septum, and lessens any congestion about that part which might militate against the healing process. The risks of the operation are very slight ; so far as my own practice is concerned I have never met with a fatal case, nor one to cause any real anxiety. I have operated at all ages between sixteen and seventy-three, and have not found that age makes much difference in the result. Young women recover more quickly, and older ones with fewer complications. Some people may think it hardly wise to operate on very old people who have put up with the trouble 40 or 50 years already ; but when we find, as in the case of a lady I operated on recently, that the rent had allowed an old prolapse of uterus and bladder to become such a burden, that she had been condemned to an invalid chair and sofa life, after being a very active woman, and by means of an operation we can restore her to activity for her remaining days, surely it is our duty to render such service. The mental relief in cases of this kind is quite disproportionate to even the delightful sense of restored physical comfort.

For my part I cannot quite understand why old people should not share the benefits which surgery can offer, not only in these cases but in others, simply because it seems hardly worth while to incur any risk. I have never had to regret operating on elderly women for perineal deficiency. Upon the whole it is one of the most safe and satisfactory of all gynæcological procedures, and might with advantage be resorted to in many cases which are met with, but are considered too slight to demand surgical interference.