Perineorrhaphy, with special reference to its benefits in slight lacerations : and a description of a new mode of operating / by Edward W. Jenks.

COMPLIMENTS OF THE AUTHOR,
84 LAFAYETTE AVE., DETROIT, MICH.

PERINEORRHAPHY,

8.

WITH SPECIAL REFERENCE TO

ITS BENEFITS IN SLIGHT LACERATIONS,

AND A DESCRIPTION OF

A NEW MODE OF OPERATING.

BY

EDWARD W. JENKS, M.D.,

Professor of Medical and Surgical Diseases of Women and Obstetrics in Detroit Medical College; Honorary Member of the Cincinnati Obstetrical Society; Corresponding Member of the Gynecological Society of Boston; Fellow of the Obstetrical Society of London, and of the American Gynecological Society, etc., etc.

(WITH EIGHT WOODCUTS.)

Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, *Vol. XII., No. II., April*, 1879.

NEW YORK:
WILLIAM WOOD & COMPANY, 27 GREAT JONES STREET.
1879.

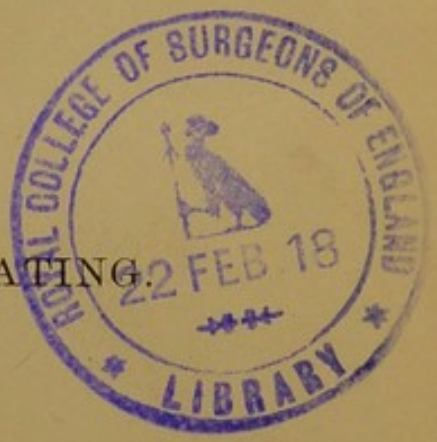
PERINEORRHAPHY,

WITH SPECIAL REFERENCE TO

ITS BENEFITS IN SLIGHT LACERATIONS,

AND A DESCRIPTION OF

A NEW MODE OF OPERATING.



BY

EDWARD W. JENKS, M.D.,

Professor of Medical and Surgical Diseases of Women and Obstetrics in Detroit Medical College; Honorary Member of the Cincinnati Obstetrical Society; Corresponding Member of the Gynecological Society of Boston; Fellow of the Obstetrical Society of London, and of the American Gynecological Society, etc., etc.

(WITH EIGHT WOODCUTS.)

Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, *Vol. XII., No. II., April*, 1879.

NEW YORK:
WILLIAM WOOD & COMPANY, 27 GREAT JONES STREET.
1879.

SINCE this paper was printed the author has accepted the chair of **Medical and Surgical Diseases of Women and Clinical Gynecology** in the **Chicago Medical College,** expecting to remove permanently to that city sometime prior to October 1st, 1879.

DETROIT, April 25th, 1879.

PERINEORRHAPHY,

WITH SPECIAL REFERENCE TO ITS BENEFITS IN SLIGHT LACERATIONS, AND A DESCRIPTION OF A NEW MODE OF OPERATING.[1]

BY

EDWARD W. JENKS, M.D.,

Professor of Medical and Surgical Diseases of Women and Obstetrics in Detroit Medical College, etc.

(With eight woodcuts.)

VERY much has been written of late years on perineo-vaginal surgery, and many different modes for producing the same results in the class of operations which come within this branch of surgical gynecology have been brought to the attention of the profession. It is, therefore, with considerable reluctance that the following paper is presented to-night, but owing to the fact that all of my auditors are practical gynecologists, while the majority are eminent, and very widely known as such, I trust that the essay may at least be the means of causing a discussion upon perineo-vaginal surgery which cannot but be valuable if participated in by the distinguished gentlemen who are here present.

In 1877, the writer read a paper before the Michigan State Medical Society, entitled, "Some of the Plastic Operations within the Vagina," in which were mentioned some new procedures in the operation for laceration of the perineum, and later one of his clinical lectures was reported by Dr. Hersey for the *Toledo Medical and Surgical Journal*, in which brief allusion was made to the same. Owing to the limited circulation of the Society's Transactions, and the fact that the clinical report was a mere abstract, some of his valued gynecological friends have expressed a desire that another paper should be published, or at least that the writer's mode of denuding the parts in plastic operations within the vagina should be given greater publicity. This would have been done at the last meeting of the American Gynecological Society but for illness, which prevented the preparation of a paper or even attendance at the meeting.

[1] A paper read before the Cincinnati Obstetrical Society, Jan. 8th, 1879.

In the following paper, the subject of perineorrhaphy or perineoplasty will be but in part considered, the object being more particularly to direct attention, *first*, to the incalculable benefit which may be obtained from proper plastic operations within the vagina in a class of lacerations which have as a rule been considered as so slight and insignificant as not to be productive of any evil consequences. *Second*, the description of an operation in which the parts can be more easily and effectually denuded than has been customary, together with other procedures which help to simplify the operation.

Among the many accidents incident to child-birth is laceration, more or less extensive, of the perineal region of the vagina, which differs in degree from a simple tearing of the fourchette to complete laceration of the perineum. The latter accident, if not immediately recognized by the accoucheur, is sure to be afterwards by the patient. The lacerations occurring between the two extremes just mentioned remain not unfrequently undiscovered during a period of years, and in the mean time patients suffer from the many accompaniments of uterine disorders occasioned by the lack of proper support to the uterus, its retarded involution, and the dislocation, to a greater or lesser extent, of all the pelvic organs. It is not my purpose to discuss the prophylaxis of laceration of the perineum, nor to dwell at any length upon the primary operation for either complete or incomplete laceration. I cannot, however, forbear adding a word concerning the primary operation, the success or failure of which depending, as it does, upon causes not unfrequently overlooked. For instance, we find many advocating, in all cases of laceration, that the parts be brought together by sutures as soon after the delivery of the child as possible. Others seem to hold the primary operation in low esteem, as success does not always follow the immediate apposition of the parts, for it sometimes happens that, in spite of careful stitching and attention to every precaution, union does not take place, and upon removal of the sutures, the lacerated perineum yawns as much as if nothing had been done. The explanation of this is, I believe, easily made. In cases of labor where there has been much delay, or much manipulation within the parturient canal with the hands alone, or long con-

tinued efforts with any instruments, a semi-pathological condition of the perineum is produced, and if it becomes torn the reparative process is very much retarded. If such a perineum is sutured, union does not take place. On the other hand, if laceration occurs in a rapid labor, whether unaided, or from the use of instruments, if the perineum is immediately sutured, or even if sutures are put in within twenty-four hours after the completion of labor, complete union will, as a rule, follow.

My own rule of practice has been, of late years, in accordance with the above expressed views. In the primary operation, I prefer to put in sutures as soon as possible after delivery of the child, while the parts are benumbed by the pressure to which they have been subjected; for material, I prefer silk, and for the better adjustment of the sutures, I use, when attainable, the long needle, the same as in the secondary operation, and, as in the secondary operation, I endeavor to keep the first and second sutures buried beneath the tissues, that they may not act as setons. These sutures are usually removed four or five days after insertion, first moving the bowels and then, after the sutures are removed, keeping the bowels locked for several days, until firm union is attained.

As already remarked of complete lacerations, if they are not recognized immediately by the accoucheur, they are sure to be soon after by the patient. It is of this class that the most has been written, and for which the benefits derived from skillful operations are never called in question. I desire briefly to direct attention more especially in this paper to a class of lacerations more commonly unrecognized. I refer to those where there has been but partial laceration, and in which the evil consequences are not made immediately apparent, but yet one of the important factors of pelvic disorders of child-bearing women.

The supports to the uterus are both above and below; it is held in position by the various ligaments—its attachment to other pelvic viscera, while it and contiguous viscera are greatly dependent for the maintenance of their normal position upon the integrity of the vagina. The vagina is a musculo-membranous canal, with only the anterior and posterior walls in apposition, and when normal and at rest, the walls are in close contact. A longitudinal section of the female pelvis demon-

strates that the vagina and rectum correspond to each other in their direction only in the upper half of the former; below, the rectum is directed backward, so that there is a triangular-shaped space or body between the lower portion of these two canals. Now, if in the process of parturition, when this body is carried forwards and outwards, it is torn to a greater or less extent, and heals only by second intention, then the support to the pelvic viscera is weakened proportionately to the extent of laceration.

The name of perineal body has been given by Savage[1] and also adopted by Thomas[2] as applied to that portion midway between the posterior vulvar commissure and the anus, where the perineal structures meet and become, as it were, pressed together by a great accession of elastic tissue, while their identity is not wholly lost; the result of this combination is a body elastic and resistant. The integrity of the female perineum, and, to a very great extent, the normal position of all the pelvic organs, depend upon this perineal body. Fig. 1 represents a profile view of the perineum copied from an article upon perineorrhaphy by my esteemed friend, Prof. Parvin. A to C represents the rectal wall. A to B, the cutaneous surface. B to C, the vaginal surface. The point of divergence of the two canals alluded to is at C.

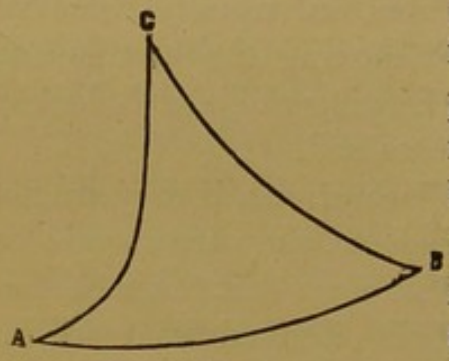


FIG. 1.

In Thomas'[3] work are three diagrams, one representing the perineal body perfect, with the vaginal walls well sustained, another where it has been removed by rupture and both walls are robbed of support, and a third for the purpose of showing the perineum improperly repaired, the perineal body not restored to place, nor the vaginal walls well restored. The text accompanying these diagrams is in the lucid and unexceptional language which characterizes everything from the pen or lips of that distinguished gynecologist, but the diagrams are anatomically incorrect, as they do not exhibit the divergence of the vagina and rectum, but at a certain point

[1] Savage, on Female Pelvic Organs, London, 1870.
[2] Thomas, Diseases of Women, 4th Ed., Philadelphia, 1874.
[3] Op. cit., page 126.

rather show the rectum to be a straight canal. It is not necessary for the purpose of this paper to reproduce the diagrams of Thomas or to accompany it with anatomically correct ones, as reference to the profile view of Fig. 1 will suffice.

It is not an uncommon thing for some physicians with large obstetrical experience to assert that they have had no cases of perineal rupture; these gentlemen may have been so fortunate as not to have had patients with complete laceration. The writer, however, has had many cases of previously unrecognized incomplete laceration of the perineum among the patients of practitioners who have made similar statements to him. This is not strange when we consider that laceration to a certain extent is with very many women an inevitable occurrence, and that slight tearing is not easily recognized at the time of its happening, and further that the bad results of partial destruction of the perineal body are not apparent until, as a consequence of it, there ensues dislocation of one or more of the pelvic organs. It may be months, but more frequently the time is measured by years, that dislocations of pelvic organs as a sequence of incomplete laceration produce their discomforts and sufferings.

All lacerations of the perineum may be classed under the general heads: complete, and incomplete or partial.

Reversing the order in which they have been alluded to, I would mention first that of the incomplete variety, which includes all, from a slight tearing of the fourchette to a rupture of the perineum, not including the sphincters; the common results are the same in character, while differing only in degree. These results may be mentioned as retroversion of the uterus, prolapse of the uterus, rectocele, cystocele, and impairment or utter destruction of the sphincteric action of the ostium vaginæ. The vaginal walls descend, and as they are thus displaced, the process of involution which they normally undergo is interfered with, the circulation is impeded, and they become flabby from these pathological conditions. The uterus, which is grasped by the superior portion of the vagina, cannot retain its normal position, and hence some form of displacement ensues. Sometimes the anterior wall of the vagina descends farther than the posterior wall, and the bladder is dragged down and in this way a cystocele is formed. In

other cases it is the posterior wall, and a rectocele is formed or produced. This last will the more readily occur when the subjects are habitually constipated.

It is important to bear in mind that subinvolution of the vagina is a factor in the production of chronic pelvic disorders, second only to subinvolution of the uterus. These two conditions are not unfrequently associated, and when they are, and the perineal body is in part or wholly destroyed, the reason cannot but be obvious why disorders of function, structure, and place of the uterus and contiguous organs occur as a sequence. It is not uncommon to find a child-bearing woman with what seems to be externally a perfect perineum, but there is sagging of the vaginal walls, and only the integumentary portion of the perineum is sound, while the perineal body is almost or entirely wanting. It is this class of cases that mislead the casual observer as to the real pathogenesis of many pelvic disorders. Complete laceration is a much more grave affection, for besides the troubles incident to incomplete laceration, there are the additional ones arising from rupture of the sphincter ani muscles. A woman with rectal incontinence is truly afflicted, exciting our pity, for not only is she a physical sufferer, but in consequene of her condition she is frequently deprived of all the pleasures of social life. The diagnosis of complete laceration of the perineum needs no remarks, as nothing can be easier, but when incomplete, the task is much more difficult. The absence of a portion of the perineal body can best be determined by conjoined examination of the vagina and rectum.

The facility with which the vagina can be everted by a finger in the rectum, and the degree of uniformity in the thickness of the septum indicate loss of substance and the extent of it; further, with the patient upon her back, if the anterior and posterior vaginal walls are not in close apposition, but there seems a tendency for the lateral walls to approximate, then there can be no mistaking the existence of partial laceration. This is still more manifest by an examination with the patient in an erect attitude, for in this position there seems to be a redundancy of vaginal walls and they descend in folds, large or small, proportionate to the extent and age of the laceration, dragging with them the uterus and bladder,

and sometimes the rectum. An ocular examination of such a vagina reveals more or less obliteration, and sometimes an entire absence of transverse rugæ in the posterior wall, and sometimes cicatrices are apparent.

In many cases there is also an entire absence of sphincteric action at the ostium vaginæ. In some vaginæ, naturally capacious, the bladder pushing before it, the anterior vaginal wall forms a large cystocele which may even protrude at the vulva. With such a condition of things there will be an absence of transverse rugæ in the anterior vaginal wall; this absence is occasioned by the subinvolution, or the constant tension to which the walls have been subjected, or both. The long continuance of a vaginal cystocele produces, in addition to the discomforts attending a displaccd uterus, an irritable condition of the bladder. The prolapse of the bladder admits of a pocket for the retention of urine; the urine thus retained undergoes chemical changes and acts as an irritant to the mucous membrane of the bladder and urethra, and sometimes causes one of the most intractable and annoying forms of pelvic disorders.

It is true that there may be a condition of things favoring the formation of rectocele and cystocele other than laceration of the perineum, such as subinvolution of the uterus, pressure of the abdominal organs, increased by excess of adipose tissue in the abdominal walls, by heavy skirts and tight lacing, all of which are greatly aggravated by the common pernicious habit of constipation, and of not voiding the urine at proper intervals. If any of the causes just mentioned should exist, which might be designated as predisposing, and there should be a laceration of the perineum to a greater or lesser extent, then cystocele is quite an inevitable sequence, for the reason that the posterior vaginal wall, curving forward and composed of resisting material, is in reality the support of the less firm anterior wall; if the latter has not an adequate foundation upon which to rest, it then falls lower in the vagina. Another feature of these displacements of the pelvic organs consequent upon complete or incomplete lacerations of the perineum is the effect upon the uterus. The uterus descends low in the pelvis, being in many cases a heavy, subinvoluted organ, with its venous circulation impeded by reason of the displacement, the neck is in a condition to become easily abraded, as it usually

does, and then a profuse leucorrheal discharge is poured out which adds still further to the relaxed and sodden condition of the vagina.

These changes in the uterus are alone sufficient to render a woman's life miserable, and produce all those local and sympathetic disorders recognized as belonging peculiarly to diseases of the female generative organs. Very much might be added in this connection of the far-reaching effects upon body and mind produced by laceration of the perineum in its various degrees, and yet it would not come within the strict province of this paper.

The gentleman whose guest we are to-night, has in unmistakably plain and well-chosen words given to the profession a valuable paper, showing the mental and psychical disorders which the simpler varieties alone of perineal laceration produce.[1]

TREATMENT.—I do not wish to underrate the value of perfectly adjusted pessaries in the treatment of displacements of the uterus. It is an undoubted fact that, by holding the uterus in its normal position, they favor its involution after parturition; they also prevent, to a great extent, either active or passive congestion of its tissues; they may also serve to prevent descent of the vaginal walls. But where a portion of the perineum is destroyed, it is sometimes difficult or impossible to make a pessary accomplish what we desire; if, however, we succeed in holding the uterus and pelvic organs in their normal position with one, it does not cure the trouble, and serves only as a temporary measure. With the removal of the pessary the organs are again displaced. Besides, it is a foreign body liable to get out of position and produce irritation or even serious inflammation. No physician skilled in the treatment of diseases of women is willing to insert a pessary and allow the patient to pass from his observation, as he well knows the troubles to which it may give rise. We cannot here discuss the advantages and disadvantages of pessaries or say a word about the numberless kinds and patterns. While one would not willingly dispense with them in the treatment of uterine diseases, it is not well to expect too much of them.

[1] Prof. Thad. A. Reamy. Upon the Simpler Varieties of Perineal Laceration. A paper read at the meeting of the American Gynecological Society, held in Boston, in 1876.

Of their use in the treatment of partial perineal laceration it may be well to make merely an allusion. A pessary, if it is perfectly fitted (none other should a physician allow to be worn), may in a case of incomplete rupture afford such perfect relief for a time that the patient feels as if she were cured, but it cannot restore what is lost, nor cause a new perineal body or a portion of one to come into existence. Neither is it a pleasant thing for a woman to contemplate the necessity of wearing a pessary during a long period of years in order to insure her any degree of comfort. There is to my mind but one means of radical cure, and that is by an operative procedure. There cannot be any question about the propriety of an operation for complete laceration of the perineum, and in the entire domain of gynecological surgery there is no operation, when properly performed, that is more uniformly satisfactory. But surgeons may sometimes hesitate to operate in the partial lacerations, and more especially in the class I have spoken of, that are so liable to remain undetected. One cannot but recognize the fact that the impetus given by many of the pioneers in uterine surgery, by reason of their brilliant achievements, has of late years had a tendency to make the surgical part of gynecology occupy rather too prominent a position, and cause to be neglected medical and psychical considerations in the treatment of women's diseases. My distinguished friend, Prof. Fordyce Barker, in his advocacy of the importance of medical gynecology, has truly said: "The sole justification of any operation which involves suffering and danger to the subject must be the strong probability, based on scientific knowledge, that compensating good will be the result."[1]

Entertaining the same views, I should be very loth to advocate such an operation as I propose, if it was attended with any particular risk, or even if there were slower and more conservative means of cure. My belief concerning the propriety of a plastic operation to restore the vagina to its normal condition in partial laceration, where there is any displacement of the pelvic organs, or discomfort as a consequence,

[1] Medical Gynecology. Annual address delivered at the meeting of the American Gynecological Society in 1877, by the President, Fordyce Barker, M.D., LL.D.

is not based upon the observations of two or three cases, but upon a large number occurring in both hospital and private practice. So I can truly say, that within my own experience, the operation has proven as satisfactory as the one for extensive laceration. There are, of course, many patients who could be relieved by an operation, but who will not submit, and then it merely remains for the physician to treat them by pessaries, or such means as he deems best.

I have myself operated upon the perineum and vagina to remedy the laceration produced by parturition, by all of the published methods, unless it be the one described by Demarquay, which seems to me a needlessly complicated one. An important desideratum in connection with any surgical procedure is that it shall be as simple as possible. For the past five years I have operated by what is deemed a simple and easy method, and in the class of cases more particularly under consideration, there has not been a single instance of failure.

The operation of perinorrhaphy is fully described in every modern work that treats on the surgical diseases of women. Ancient writers speak of it, but only in a vague sort of a way. Ambroise Paré is credited with being among the first to suggest it; but he gives no description of his mode of operating, more than to describe a simple stitching up of the perineum at the time of rupture, and even of this he says that it is "*un grand désastre à la pauvre femme*" on account of the cicatrices, which render it necessary, if the woman becomes pregnant again, to cut the perineum when she is delivered, lest it be torn, as he adds he himself has done twice "*en cette ville de Paris.*"[1]

Guillemeau,[2] the pupil and successor of Paré, is believed to be the first writer to describe the secondary operation, which he performed successfully six weeks after childbirth in a case of complete laceration. The same method was pursued by him as in operations for hare-lip.

In the nineteenth century, the operation has been revived, and there have been many modes described, all having in view an accomplishment of the same thing. All of these described operations have been with reference to more extensive lacera-

[1] Œuvres Complets d'Ambroise Paré, par J. F. Malgaigne, Paris, 1840.

[2] Les Œuvres des Guillemeau, p. 354, Paris, 1612.

tions than those of which Prof. Reamy[1] has written, and for which, in his opinion as in my own, the same necessity for operating exists.

The performance of perineorrhaphy is essentially the same in one variety of laceration as in another, with the exception of the additional means made use of when any portion of the recto-vaginal septum is torn, and although prominence has been given, thus far in this paper, to incomplete lacerations, it has been rather because of the results proceeding from them than from any marked difference in the treatment of the different forms. Therefore, the remaining portion of this paper will be upon perineorrhaphy as it relates to any or every variety or degree of laceration to which the perineum is subject.

Previous to operating, the patient's general health should be made as good as possible by hygienic or therapeutic means, and then the time selected for operating should be a week or ten days after a menstrual period. The bowels ought to be thoroughly emptied by a cathartic twelve hours before the appointed time for operating, and an hour before, the rectum should be washed out by a copious injection of warm water. The patient being etherized, I begin by nicking with scissors the anterior margin of the surface to be denuded, at the juncture of integument and mucous membrane; next, I introduce two fingers of the left hand into the rectum, while assistants hold the labia apart, it being important that they are held uniformly tense. I use scissors slightly curved and sharp pointed (Fig. 2) to denude

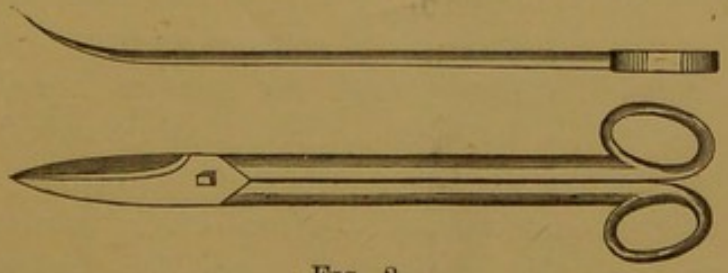


Fig. 2.

the mucous membrane. I use neither tenacula nor tissue forceps, but, with the parts tense, snip a hole in the mucous membrane in the median line, close to the integument, and then inserting the scissors with a cutting motion into the small hole made, I continue to dissect the mucous membrane away from the subjacent tissues without removing the scissors, first going

[1] Op. cit.

up the septum as far as is desired, and then laterally, first on one side, and then on the other, without removing the scissors or once bringing their points out from beneath the mucous membrane, as shown in Fig. 3.

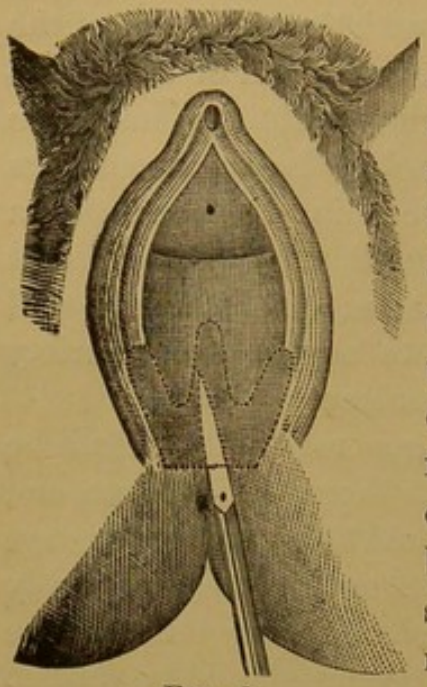


FIG. 3.

Sometimes, instead of beginning my dissection at the median line, I begin at the nick on the left labium majus, running the points of the scissors beneath the mucous membrane, and dissecting it away from the subjacent tissues back on the left lip, then up the recto-vaginal septum as far as I deem it necessary, and from thence forward on the right lip to a point opposite from which I started (marked by the nick), without allowing the scissors to come out from beneath the membrane, unless they are accidentally turned out by cicatricial tissue. Then with blunt-pointed scissors cut away the dissected flaps. The bared surface thus exposed is much the shape of a right-angled triangle, with the base directed outward, or it has been compared in shape to a butterfly, with wings spread and tail directed upward.

The advantages of this mode of denuding are, (*a*) the rapidity with which it can be done; (*b*) the absence of hemorrhage in the vagina, as no blood escapes except at the locality where the scissors enter beneath the mucous membrane; (*c*) the ability by which the operator can make complete denudation, as the discoloration beneath the membrane marks the route the scissors have taken. Several of my brother gynecologists have tried this method of denuding, and are highly pleased with it. Among them is my friend Dr. Albert H. Smith, of Philadelphia, who, thinking he could better denude with a knife than scissors, had one made, which he found after several trials to be a very satisfactory instrument, by which he can denude much more rapidly, and yet on the same principle as with scissors. The knife (Fig. 4) has a dart-shaped thin blade with double cutting edges. The patient,

when the knife is used, is put in the same position, and with the same degree of tension of the parts as for scissors; the knife is inserted beneath the mucous membrane in the median line, at its juncture with the integument, and from thence

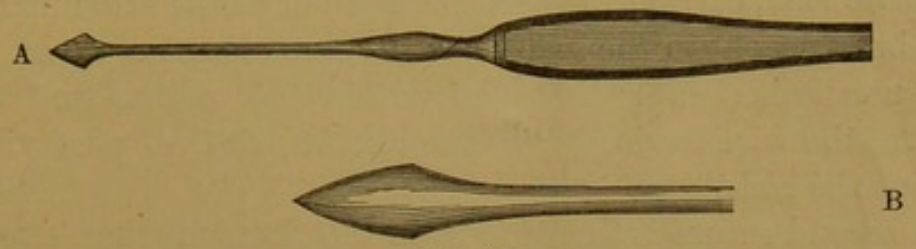


FIG. 4.[1]

the sub-mucous incision is made on one side, then upon the other, then up the septum the required distance, after which the flaps are cut away with blunt-pointed scissors. I have, up to the present time, used the knife devised by Dr. Smith only three times, and although, as a rule, having preference for the scissors over the knife in all plastic operations, I have been delighted with the rapidity and ease by which I have been able to operate with the knife which he kindly sent to me.

As there are many surgeons better skilled in the use of the knife than scissors, the instrument devised by Dr. Smith cannot but be acknowledged as a valuable addition to the gynecological armamentarium.

The next step in the operation after denudation is the adjustment of sutures. In cases of complete laceration, or when any portion of the septum is torn, no method can be better than the one described by Dr. Emmet for bringing the lacerated portion of the septum together. Having done this in the class of lacerations just mentioned, the remaining sutures are put in as in incomplete lacerations, so that, with the exception of this procedure, sutures in every instance are adjusted similarly, and after the following manner. A long, slightly curved needle, fixed in a handle, is threaded with silk, to which is attached silver wire of large size, or if the needle has an eye sufficiently sunken, the wire may be put in it. The needle is then inserted in the left recto-iliac fossa, a little back of the anterior margin of the anus, while at the same time the left index finger is put into the rectum to help guide the needle which is carried deep

[1] A represents the appearance of the knife, about one-third of its size. B shows the shape and full size of the blade.

through the septum to the median line just above the denuded surface within the vagina; by means of a tenaculum the suture is then pulled from the needle, the latter being withdrawn empty. The empty needle is then inserted on the opposite side, carried through the septum in the same manner, and brought out in the vagina at the same location as at first. The needle is then re-threaded within the vagina and withdrawn, the wire having made the circuit with no part visible except the ends.

A second suture is then put in in the same manner, starting the needle about one-half of an inch anterior to the first and passing through the median portion of the septum a little above it, and bringing the needle out at a corresponding point on the opposite side. A third suture is put in anterior to the second, and sometimes a fourth, but neither of these is carried into the septum. As the first and second sutures are the important ones, the wire should be larger than the others, and for material silver is more reliable than anything else. I have used iron wire silvered, but unless recently plated it is liable to break and defeat an otherwise successful operation. To secure the sutures after the nates are brought together, one should make sufficient traction upon the first suture to bring the parts into perfect apposition, and then slide upon the wire a perforated shot, which is then compressed, and after being twisted another shot is put on and compressed to guard against all danger of slipping from coughing or vomiting. The second suture should be treated in like manner, but the remaining sutures require only a single compressed shot, or the wire may be twisted. With the limbs well secured, the operation is then complete. As the denuded parts have been compared in shape to a butterfly with spread wings—the traction, if just sufficiently made, brings the pared parts together like doubling a butterfly's wings over its back and then fastening them. The wire possesses, in one respect, a great advantage over silk, or any form of suture, in that it serves as a splint to hold the parts in proper position.

In cases where there is marked redundancy of the vaginal walls, and they lie in folds, there is more to be done than simply restoring the perineum.

Reamy's method is to denude a number of parallel strips up

the recto-vaginal septum, and bring the edges together by fine silver sutures. My own method is, instead, to denude one broad portion of the septum, from an inch to two inches in length, or such a distance as I deem requisite, as indicated by the absence of rugæ. For bringing the edges together I have used fine silver wire; but it is very objectionable, on account of the difficulty of removal without injury to the perineal wound. The same may be said of silk, although I have, in a few instances, used sutures of Chinese silk, and made no attempt at their removal—perfect union occurring—while the silk either decayed through and was cast off, or else was absorbed. *Theoretically*, catgut is the best material; but *practically*, it has proved in my hands a failure, when reliance has been placed upon the ordinary knot remaining tied.

If two operations are made, one for the redundant walls, and another for absence of the perineum, then, if made in the order above named, there is nothing better for sutures than silver; but a more common and better plan is, to have but one operation. As this is an important step, where there is much prolapsus vaginæ, it is necessary that a plan be adopted of putting in sutures and removing them without interfering with the firm and perfect union of the perineum. The plan I have adopted is as follows: After denuding the recto-vaginal septum above the point reached by the deep perineal suture, such a distance, and such a width as is deemed requisite, the sutures are put in transversely about three to the inch. For the accomplishment of this part of the operation, I take fine catgut and slide down upon it a No. 2 perforated shot, but do not compress it; then following that a piece of vulcanized rubber tubing two and one-half inches long (a No. 1 or 2 English

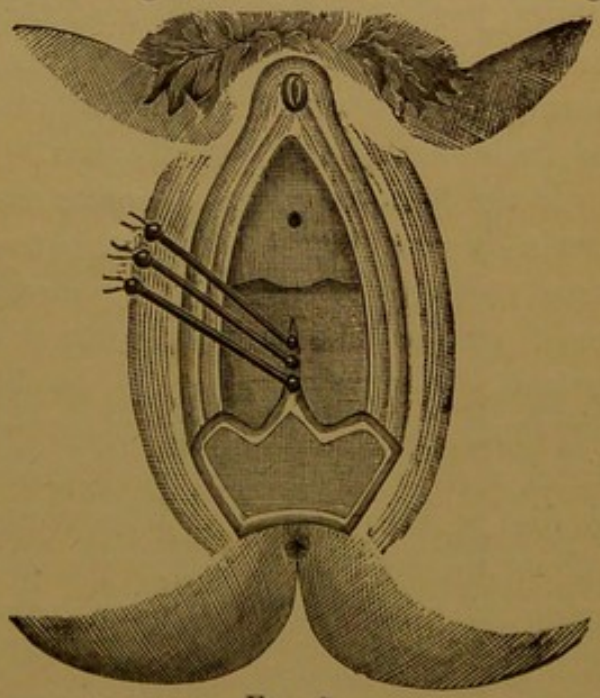


Fig. 5.

male catheter, cut into sections of the same length, does well for the purpose), at the end of which I put upon the catgut another shot, which is firmly compressed. About three or four sutures inserted in this way are ordinarily required for remedying the redundant posterior vaginal walls, all of which are adjusted as just described, and then left to protrude beyond the vulva, as seen in Figs. 5 and 6. Fig. 6 also shows the perineal sutures adjusted, only none are double-shotted as should be shown in the two posterior sutures. The object of the loose shot and tubing is to make easy the removal of the sutures, as by simply cutting the catgut on one side the remaining portion can be easily drawn out without disturbing the feebly-united perineum.[1] I have tried this plan with silver, but with very unsatisfactory results, owing to the difficulty in removing sutures of this material of the required length, and the liability of their tearing the wound apart.

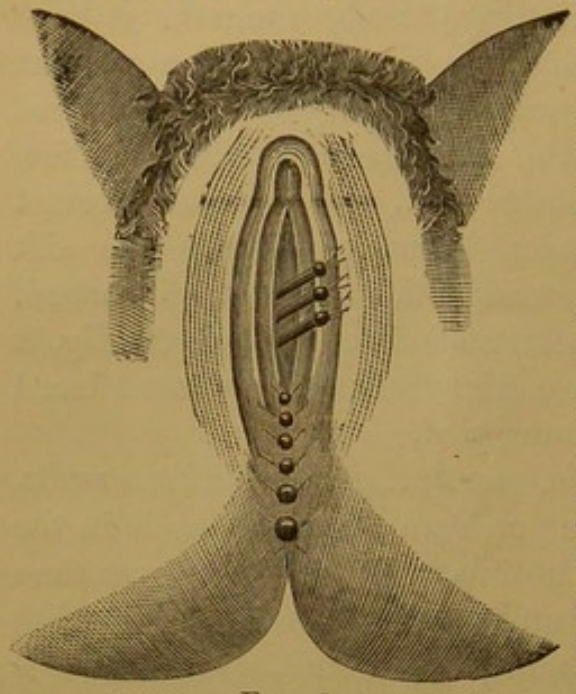


FIG. 6.

In the after-treatment of these cases, I think mistake is often made by washing out the vagina too soon. It should not be done earlier than forty-eight hours after the operation. The most grateful wash is a weak solution of permanganate of potash. The bowels should be kept constipated as a rule, although the opposite or causing them to move twice or three times a day meets with the approval of many gynecologists. A diet which affords but little excrement should be prescribed. About the eighth or ninth day the metallic sutures should be removed, reversing the order in which they were inserted. The patient should not be allowed to sit up before the fourteenth day after the operation, nor walk about under three weeks.

Occasionally we meet with patients where an operation to

[1] It not unfrequently occurs, if small-sized catgut is used, that the portion beneath the tissue is absorbed. Union is then secured, while there is no trouble in removing sutures.

restore the perineal body and diminish the redundant posterior wall will not suffice. This is particularly the case when there is a large cystocele of long standing; the mere restoration of the posterior vaginal wall and perineum not being sufficient, it becomes necessary to perform a plastic operation upon the anterior vaginal wall. The necessity for such a procedure should be determined upon, if possible, before an operation in the perineal region is made; this can be done either by bringing the posterior commissure together by the hands, or, as I have sometimes done, by catch-forceps or *serrefines* in the vagina, and externally upon the perineum, thus temporarily

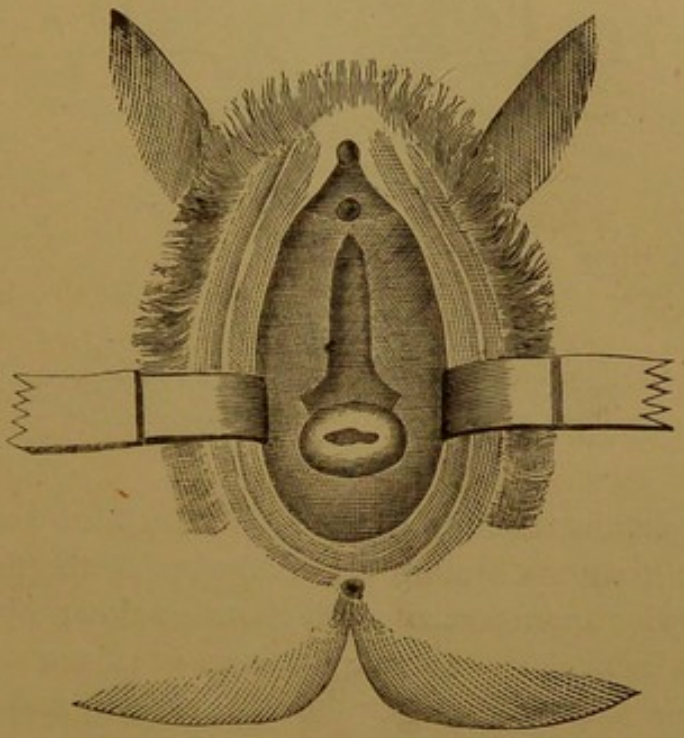


Fig. 7.

restoring the parts, and then ascertaining if, when the patient stands, the cystocele persists in protruding and the uterus in descending. The dissecting of a V-shaped piece of mucous membrane from the anterior wall, and bringing it together by sutures, after the method of Emmet, will suffice in some cases; but experience has taught me that in the majority of cases it is of no permanent value, and that a better mode of diminishing the redundant anterior wall, holding up the uterus, and reducing the cystocele is by denuding the parts more in the shape of a capital letter T, the arms of the letter being located superiorly at the junction of the vagina and cervix uteri (Fig.

7). Then the pared edges are brought together by six or eight fine silver sutures transversely and about the same number longitudinally, as represented by Fig. 8. The sutures can be removed in seven or eight days, and in from ten to fourteen days after, the posterior wall and perineum should be operated upon in the manner described.

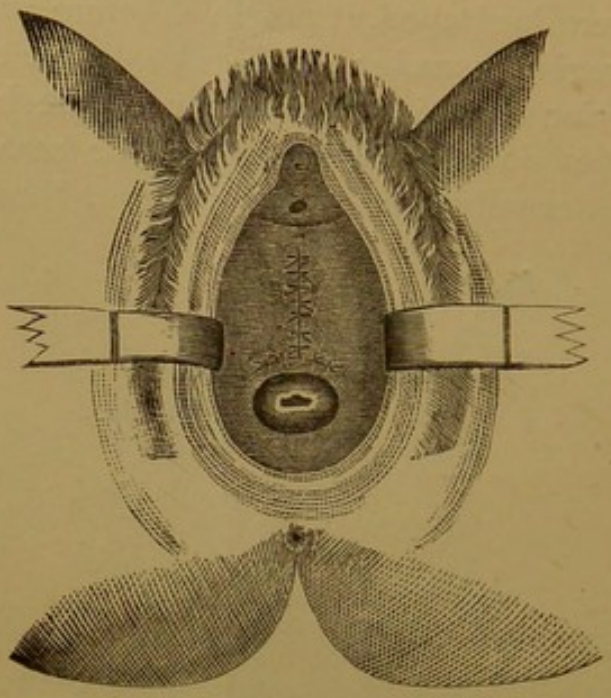


FIG. 8.

It is important that the last-named operation should not be delayed long after the first, as, otherwise, if the patient walks about, the yielding anterior wall, crowded down by the viscera above, and lacking the resisting power of a normal perineum upon which to rest, will gradually descend, and the advantages which might have been gained will be in a great measure or entirely lost.

84 LAFAYETTE AVE., DETROIT, MICHIGAN.