Brooklyn Med J 1890 V-4

NOTE ON EPISIOTOMY.

BY CHAS. JEWETT, M.D.

Read before the Medical Society of the County of Kings, June 17, 1890

According to Olshausen perineal lacerations are unavoidable in fifteen per cent. of primiparæ without episiotomy. This may be taken as the extreme limit attainable in skilled hands. In general obstetric practice the proportion is certainly not less than 20 to 30 per cent. and that, too, of tears sufficient to impair in greater or less degree the function of the pelvic floor. On *a priori* grounds alone, then, the operation

Digitized by Google

history-of-obgyn.com
obgynhistory.net

of episiotomy is entitled to hold a more prominent place in the obstetric procedure than is accorded it by most writers. Owing in part to the feeble endorsement it has received at the hands of obstetric authors this measure is almost wholly neglected by practitioners. The majority of physicians I undertake to say have never performed it at all. Another reason why it has not received more attention is to be found in the fact that a laceration is generally looked upon as capable of causing no more damage to the pelvic floor than is done by the incision and it is believed that it may be quite as easily repaired. The fact is, however, that a laceration of the perineum is frequently, I may say usually, a by far more complex lesion than a simple separation of the structures in a single plane. It is oftener a sundering of the fasciæ and the muscular structures in several planes. It follows therefore that the restoration of the perineum to its original integrity after a laceration is a by no means simple operation.

A greater or less degree of relaxation of the pelvic floor with a corresponding gaping of the introitus is a too common result of suture even by expert operators. The incision on the other hand divides the structures in a single place and permits an easy and complete restoration of the parts.

Even should the incision be extended by a tear or should lacerations take place at other points the repair is still materially simplified and the result more satisfactory than would have been possible without episiotomy. The argument that incision adds to the danger of sepsis does not hold in aseptic practice, and in the event of septic exposure a complicated laceration is more favorable to absorption than a clean cut incision. From these considerations I have been led to make more frequent use of episiotomy for the prevention of perineal tears, and the results in my experience have borne out my expectations. I have not always succeeded in wholly preventing lacerations nor have I succeeded in restoring the perineum in all cases to its primitive integrity, yet in no case have I had reason to regret the incision and in none have I failed of a better repair than could have been reasonably expected without the incisions. Increased experience, too, I am sure, adds increased value to the procedure. It is not called for for the prevention of slight tears; but in any case when the laceration is likely to extend beyond the first degree the incision is better than the tear. I have been frequently struck with the depth and solidity of the perineal body after a typical episiotomy which had been sutured and healed. The tonicity of the pelvic floor is in marked contrast with that which usually follows the immediate suture of a deeply lacerated perineum.

My method is briefly as follows: The instrument I have used is a blunt pointed tenotomy knife. Any good blunt pointed bistoury,

Digitized by Google

history-of-obgyn.com
obgynhistory.net

however, answers the purpose. The knife is passed flatwise alongside the head, its cutting edge turned outward and the incision carried to the required depth. Much depends on properly timing the operation. In many cases it will be found possible to wholly anticipate the tear. Yet the incision should by no means be omitted because a laceration has already commenced where the tear is certain to become extensive without interference. The incision is always best made during a pain while the resisting ring is rendered tense by the pressure of the head. The exact situation of the resisting girdle is more easily determined and the cut is more easily made at this time. Placing the index finger of the free hand just within the introitus as the head is forced down by the pain the cord-like girdle is readily felt and it is this only which should be divided. The point of division should be about one-fourth way from the perineal raphe to the clitoris. This in the distended condition of the parts during a pain is sufficiently far back to avoid injury to the duct of the vulvo-vaginal gland. The incision should be practised on both sides. The depth of the cut need not usually exceed a quarter or third of an inch in the stretched condition of the parts. Its direction should be at right angles with the girdle of resistance at the point cut. It may extend down to the skin but need not invade it, and may be about three-fourths of an inch in length. While various other methods of incision have been suggested and practised the foregoing seems the simplest and the most effectual. Cohen's subcutaneous tenotomy of the bulbo-cavernosus is painful, is liable to injure the corpora cavernosa and moreover does not accomplish the purpose. Nor can I see any advantage in the multiple incisions of Schultze and others over the single division of the ring on each side. Tarnier recommends an incision of the perineum beginning in the median line and passing obliquely to one side, but this divides more important structures than the method adopted and affords no more relief to the over-distention. Pallen's method of cutting above the ducts of Bartholin is liable, as Garrigues remarks, to wound the vaginal bulbs. Garrigues prefers blunt scissors to the knife as more efficiently accomplishing just the object aimed at, cutting neither too much nor too little. The objection to the scissors is the difficulty of using them during a pain. Such at least has been my experience. At the close of labor the incisions as well as lacerations that may have occurred in spite of the incisions should be invariably closed with sutures. For this purpose I prefer catgut prepared under the supervision of the surgeon himself.

With an aseptic management of the labor and the suture and the use of a suitable antiseptic vulvar dressing during the pos:-partum week union is practically assured.

Digitized by Google

history-of-obgyn.com
obgynhistory.net