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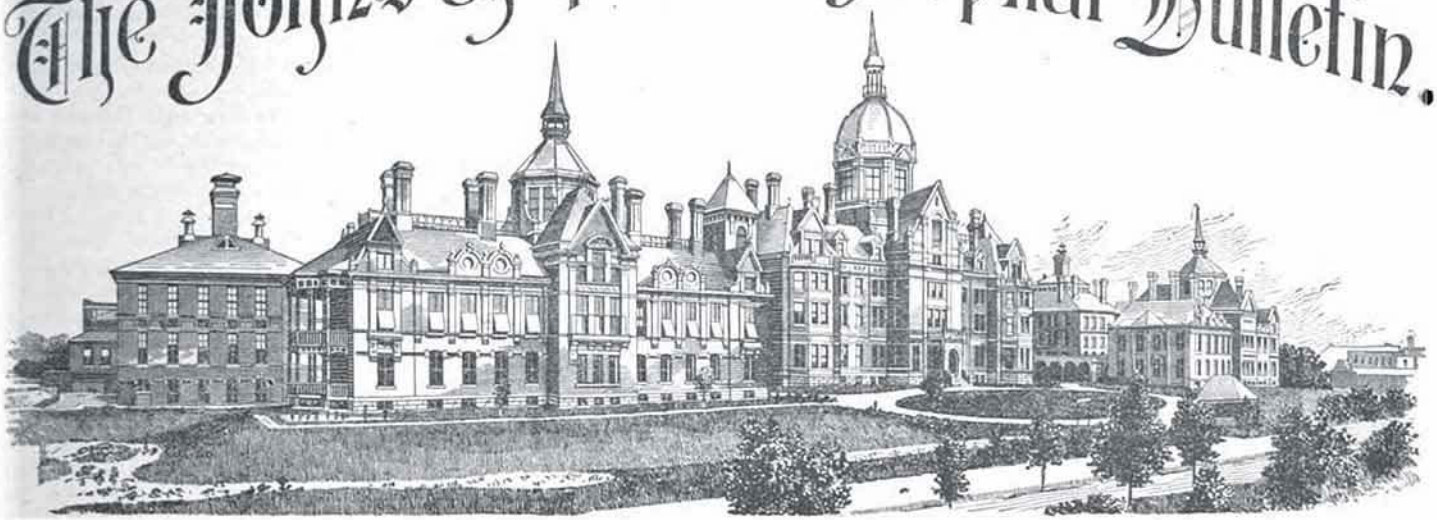

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## LACERATION OF THE PERINEUM AND VAGINAL OUTLET—REPAIR OF THE RECENT TEAR.


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From carefully prepared statistics by men of wide reputation, as well as from the admissions of conscientious practitioners who examine their cases, it may now be considered as established that laceration of the perineum is a common accident, and is in many instances far from being confined to the frenulum. But the simple recognition of the accident has not as yet brought with it a full sense of the responsibility associated with the discovery, and the subsequent distress entailed by these tears is but indifferently appreciated even by many of our specialists.

I would lay down the principle that the repair of the recent tear is the nearest approach to a restoration of the tissues to their original condition, while every secondary operation is at the best but an attempt to devise a substitute. To the former class of cases I wish briefly to address my remarks.

Such a history as the following is of frequent occurrence.—A woman confined for the first time progresses naturally and easily in her labor, until the head reaches and begins to distend the perineum; this it may pass with but little injury, not involving any more than the fourchette, but just at this moment, as the head clears the outlet, the patient is seized with a violent expulsive pain, driving the lower shoulder down into the perineum, and a deep laceration within the vagina is the result.

The postural treatment, with bound knees, so commonly employed, does not perfectly unite these torn surfaces, and the only proper procedure is to suture them at once, or at as short an interval after labor as possible.

If by oversight the tear has existed for several days, it still is not too late for this repair, the preliminary opening of the bowels by an enema of soap and water, and citrate of magnesia by the mouth under these circumstances must not be omitted.

For the immediate operation, the operator must have plenty of hot water at hand, and an ounce of a ten per cent. solution of cocaine, if several days have elapsed; in the latter case, while preparing for the operation, the surgeon should place a pledget of cotton saturated with the solution within the vagina, and allow ten minutes to elapse to secure its local anaesthetic action.

The only instruments necessary are a needle-holder, a pair of scissors, and a needle threaded with a loop to carry sutures, (*v. Fig.* 1) and perhaps a spoon to hold up the anterior vaginal wall.

The patient should be brought to the edge of the bed in front of a good light, with her buttocks resting on the perineal pad (*v. Fig.* 2.), which will conduct the water used in cleansing and irrigating the parts, by means of the apron into a bucket beneath. Upon flexing the knees on to the abdomen and separating the labia, a deep ragged rent will appear in the posterior vaginal wall, beginning at the fourchette as an apex and extending up to the columna posterior within, and on the perineal surface down towards the sphincter ani (*v. Fig.* 3). This is the deepest form of a superficial tear, involving neither vaginal sulci nor the sphincter ani without.

Fig. 1.

Needle with loop as carrier. Thread in loop ready to be used.

To proceed with the operation, the labia should be separated by the two fingers introduced (*v. Fig.* 3) within the vagina, and the whole wounded surface thus exposed. The sutures, of silk or silk-worm gut, should be passed a quarter of an inch apart, beginning at the upper angle of the wound and introducing the needle an eighth of an inch from the margin of the tear on the vaginal mucous membrane, and bringing it out at the bottom of the rent, at a point much nearer to the operator than the point of entrance, and re-introducing it at the bottom of the tear, and bringing it out on the opposite side at a point corresponding to the original point of entrance (*v. Fig.* 4).* The object of passing the sutures thus is to pull up the floor of the rent as high as possible, for, by the labor, the whole pelvic floor is depressed, and those parts lying in the middle, more so than those at the sides. By means of the sutures thus introduced, the tissues at the sides less movable than those in the centre, because of their close attachment to the pubic rami, become the points towards which the depressed centre is raised.

These sutures can be tied at once from above downwards, and by this simple arrangement, almost the whole wounded area can often be disposed of by as few as three sutures (*v. Fig.* 5).

Two or three superficial perineal sutures on the outside

*This method of introducing sutures in the recent tear has been taught for the past six years by Dr. Kelly.

(*v. Fig.* 5), between A and B, will finally give a perfect closure, thus restoring the perineum and vaginal outlet to their original integrity (*v. Fig.* 6).

The after treatment is of great importance, as there is danger of doing both too little and too much. The general injunction that the patient must lie motionless in the recumbent position, is not necessary. She should be allowed to move very gently from side to side, preventing the knees from separating widely. Another important detail of the after treatment is the regulation of the bladder. She should be allowed to pass her water if she can, and if this is impossible, a clean glass catheter should be used every six or eight hours. Before catheterization, the parts should be cleansed, particularly around the urethral orifice, with a piece of absorbent cotton. After the urine has been passed, the labia minora should be gently separated, and any fluid around the orifice of the vagina gently taken up on a piece of absorbent cotton, and a powder (*v.* ℞ below) sprinkled within

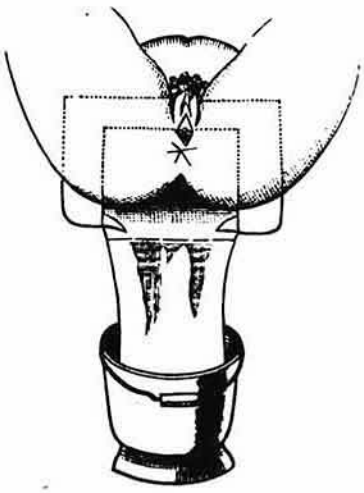

FIG. 2.

Patient in lithotomy position, on perineal pad, ready for recent operation.

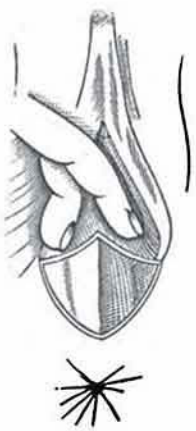

FIG. 3.

Superficial tear exposed by fingers parting labia minora.

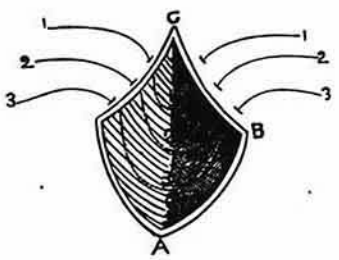


FIG. 4.

Same as Fig. 3, with internal sutures passed, ready to tie.

the vulvar orifice by means of a camel's hair brush or a pledget of cotton held by a pair of dressing forceps. By careful attention to this procedure the unpleasant and dangerous complication of cystitis will be avoided. One of two formulae may be used for the powder.

℞ P. Iodoformi, ʒi.
P. Ac. Boric, ʒ iv.
M. Exacte.
Sig = Dust on the parts,

or

℞ Ac. Salicylic, gr. vi.
Bis. Subiodi.
Bis. Subnit, āā ʒ i.
P. Ac. Boric, ʒ ii m. exacte.
Sig = Dust on the parts.

If the lochia are profuse, acrid or odorous, the vagina should be syringed out night and morning with a two per cent. warm carbolic acid, or a two per cent. creoline solution. If the injection is given by the nurse, she should be instructed exactly how to give it, being cautioned especially not to press the nozzle of the syringe against the uniting surfaces.

The bowels should be opened on the third day, by administering one-third of a bottle of citrate of magnesia, repeated every two or three hours, followed, if necessary, by an enema of a pint of warm soap and water. The only caution necessary, is that the patient should not bear down as she empties her bowels.

In from seven to nine days, the stitches should be removed. This is best accomplished by again placing the patient in the lithotomy position, with the thighs well flexed on the abdomen, and gently separating the labia and picking the stitches up one after another, with a pair of dissecting forceps, when with a little traction, the loop is exposed, cut, and the suture removed. After another week in bed, to allow complete restoration and firm union of the parts, she may rise and gradually return to her duties, taking especial care to avoid any undue exercise or work for three months. Such is the treatment of the simplest form of recent tear. There are two other forms of recent tears, which may best be understood by consulting Fig. 8, representing a sagittal section of the posterior vaginal wall and perineum, made therefore in the long axis of the vagina. The first kind, or simple superficial tear, has just been described, it extends all the way

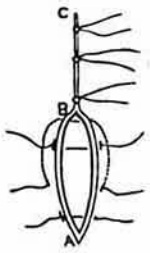


FIG. 5.

(Same as Fig. 4.)
AB, perineal surface.
BC, vaginal surface, with the three sutures tied.

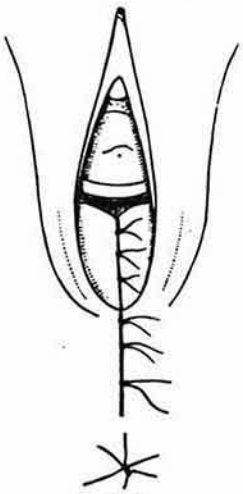

FIG. 6.

(Same as Figs. 4 and 5.)
Deep vaginal and superficial perineal sutures are tied.

from a little nick at the fourchette [F] down to the base line terminating on the vaginal surface at the columna, or at the beginning of the rugae on the posterior wall, and on the outside just above the sphincter. This area is included within and indicated by the dotted curved line OU (*outside tear*).

The second kind of tear, or rupture, involves the tissues just in front of the columna, and extends beyond this point, up one or both sulci, into the vagina. This form of tear starts median, but extends laterally up one or both arms of a Y (*v. Fig.* 7), it is the area shown in Fig. 8 above the dotted line IN (*internal tear*).

The third form of tear extends over the whole of the skin perineum through the sphincter, and a variable distance up the recto-vaginal septum, that is, consulting the diagram (*v. Fig.* 8), the portion of the perineum outside of the dotted line SP (*sphincter tear*).

The recent repair of the vaginal tear is similar to that just described, sutures being passed in one or both sulci, from the upper down to the lower limit.

The sphincter tear must first be *reduced* to a simpler form by a series of superficial sutures passed on the rectal surface, and tied in the rectum. The remaining tear can then be closed as already described.

What then is the practical importance of this subject?

No one will deny the gravity of a tear opening the bowel, as the annoyance from an inability to control the evacuations is too palpable.

The other grades of tears are, however, not so clearly recognized as important, beyond a certain vague impression, that when a tear is a "big one," it may possibly be followed at some future day by falling of the womb.

I wish to insist upon the point that every tear which extends more than one-fourth of an inch into the tissues of the posterior vaginal wall near the outlet is of sufficient importance to demand immediate repair. The effects of tear about the vaginal outlet, not involving the sphincter, are scarcely ever complained of until the woman has risen from her bed, and they may then develop but slowly in the course of months or even years; and to obscure the matter still farther, the sensations complained of are by no means always referred to their true seat by the patient herself. Any rupture around the vaginal outlet, as Dr. Emmet has well said, takes the drawing-string out of the bag and lets the pelvic viscera drop out, for as soon as this support is removed, the uterus begins pulling on the broad, the infundibulo-pelvic, utero-sacral and vesico-uterine ligaments, and sooner or later begins to travel downwards.

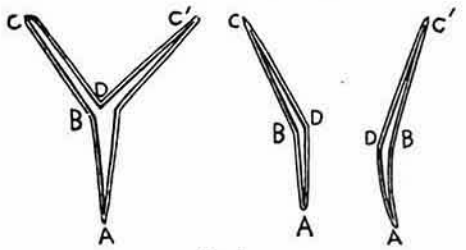


FIG. 7.

D is the apex of the columna posterior, just within the vaginal outlet. BC is the right sulcus vaginae, and BC′ the left sulcus. AB is the perineal surface. Thus the left hand figure represents a tear on the perineal surface, and extending up both sulci. The middle figure represents a tear extending up the right sulcus, and the right hand figure a tear in left sulcus.

In consequence of this, pain is felt, not in the perineum, but in the ovarian regions and in the back. In some cases there is no pain, but the woman feels a sense of weight and distress about the hips, forbidding any exertion; she is always tired, her nervous system is wrecked, she has headaches, and is practically an invalid, without apparent disease.

This fact cannot be too strongly emphasized, as it is by no means generally recognized even by gynecologists, and many cases go the rounds in search of treatment, which need no more than the simple repair of a perineal defect to restore them to health.

Another important question frequently arises: Is it as well to postpone the operation and close the perineum some months after delivery, or to wait until symptoms arise necessitating the interference?

I would answer emphatically, "do not wait."

Often the ailments arising are with difficulty traceable to their true source. At other times the patient will suffer for years rather than subject herself to an operation involving anaesthesia, denudation and suture, followed by prolonged detention in bed.

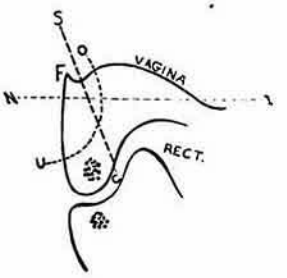


FIG. 8.

Sagittal section of posterior vaginal wall, perineum and rectum. The area embraced by OU represents an outside, more or less superficial tear. The area above IN represents a tear more on the inside of the vagina, and the area outside of SO includes the whole skin perineum and the sphincter ani.

Here the old adage literally holds true, that a *stitch in time saves nine*, for with fewer stitches the *immediate* operation secures *perfect* restoration of the parts to their original integrity; this, the best devised secondary operation can never do. To repeat with emphasis, all secondary operations are more or less imperfect substitutes, and attempts to realize the more perfect result of an immediate operation.