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THE PLACE OF THE VAGINAL CESAREAN SECTION IN OBSTETRICS

By Louis E. Phaneuf, M.D., F.A.C.S., Boston, Mass.

DÜHRSSEN, in 1890, recommended the use of deep incisions in the anterior or posterior lips of the cervix, or both, but avoiding the lateral portions, in order that the deep, irregular cervical lacerations which are likely to follow a rapid delivery through a rigid undilated cervix might be avoided. It was soon discovered, however, that the incisions did not reach high enough to overcome the resistance of the internal os, that extensive tears which were difficult to suture were likely to follow, and that hemorrhages which were hard to control sometimes occurred.

Realizing that his incisions in the cervix did not enlarge the canal sufficiently for immediate delivery, Dührssen devised the operation which, in 1895, he described as an anterior vaginal hysterotomy, and in 1896 called "vaginal cesarean section." The original operation called for only the anterior incision; later, he modified the technic by adding the posterior incision. The result of this was that it enabled him to make a shorter anterior incision, thereby lessening the danger of injury to the bladder during delivery.

Before attempting vaginal cesarean section, certain requirements are essential. The tissues must not be edematous or friable. The uterus must be movable so that the cervix may be readily brought down into the vagina. The pelvis must be ample. The child must not be too large. In the absence of these requisites, the vaginal cesarean section should not be considered, regardless of the indication.

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INDICATIONS AND CONTRAINDICATIONS

The literature of the last ten years contains very little about vaginal cesarean section. The great advantage of this method is its extraperitoneal approach of the uterus; therefore, the marked increase in safety over the classical operation. Since the more general adoption of the suprasymphyseal or transperitoneal low abdominal cesarean

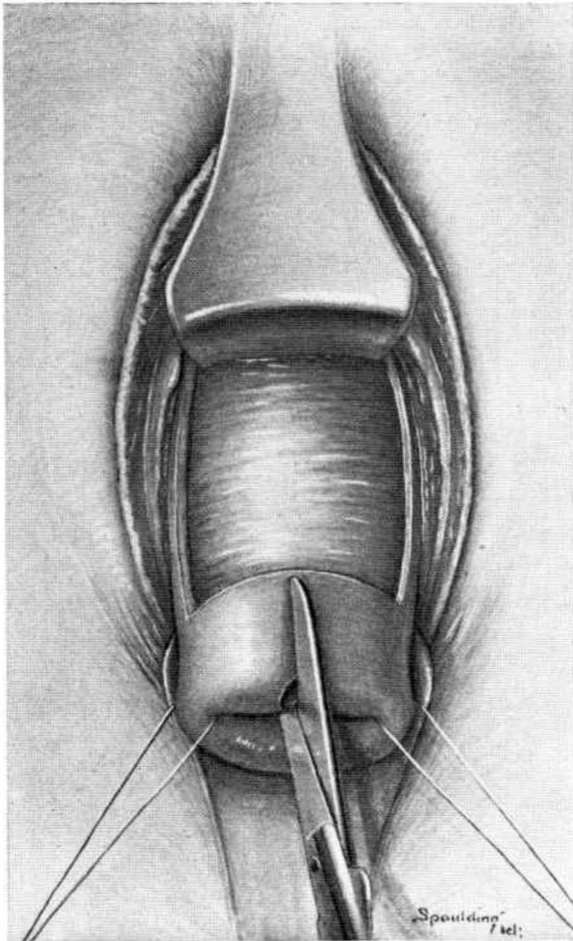

Fig. 1.—Vaginal cesarean section. The cervix is brought down by volsella. A traction suture of heavy chromic catgut is placed at each lateral angle. A transverse incision, in the anterior vaginal wall, is made at the point of attachment of the bladder to the cervix, and the bladder, together with the vaginal wall, is dissected upwards to the reflection of the anterior peritoneal culdesac. The bladder is held under a retractor, and the cervix is incised in the median line.

section, it has been found that the increased protection against infection secured by this procedure is almost as great as that of vaginal hysterotomy. For this reason, and also because of the simpler technic,

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the low abdominal operation has been substituted for the vaginal in a number of clinics. This has tended further to limit the indications of vaginal hysterotomy.

Dührssen advised his operation for the following conditions:

1. *In the anomalies of the cervix and of the lower uterine segment creating some difficulties which place the mother in danger,* including cancer, myoma, ovarian tumors, and stenosis of the cervix.

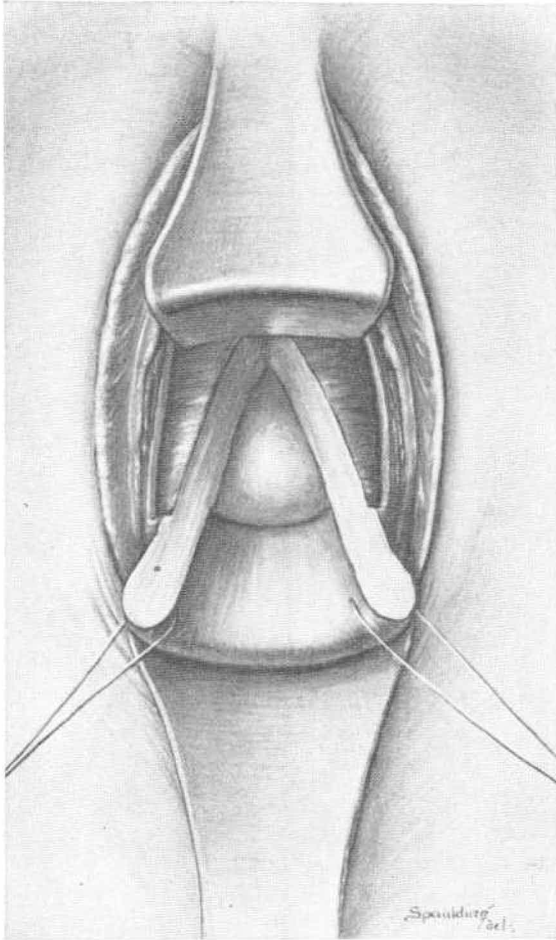

Fig. 2.—The cervix has been incised anteriorly. The membranes are shown through the incision.

2. *When the mother is in danger and when the rapid evacuation of the uterus is indicated to improve the general condition.* Lesions of the heart, lungs, kidneys; eclampsia; premature separation of the normally inserted placenta.

3. *When the mother is dead or dying.*

4. *When only the infant is in danger,* as in a slow labor and in compression of the cord.

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At the present time, while vaginal cesarean section is still recognized as a valuable procedure, most obstetricians would not subscribe to the original indications, and its range of usefulness has become much more limited.

Group I.—Stenosis of the cervix remains an accepted indication. A labor complicated by myomas and ovarian tumors, however, is best terminated by an abdominal delivery followed by the ablation of the

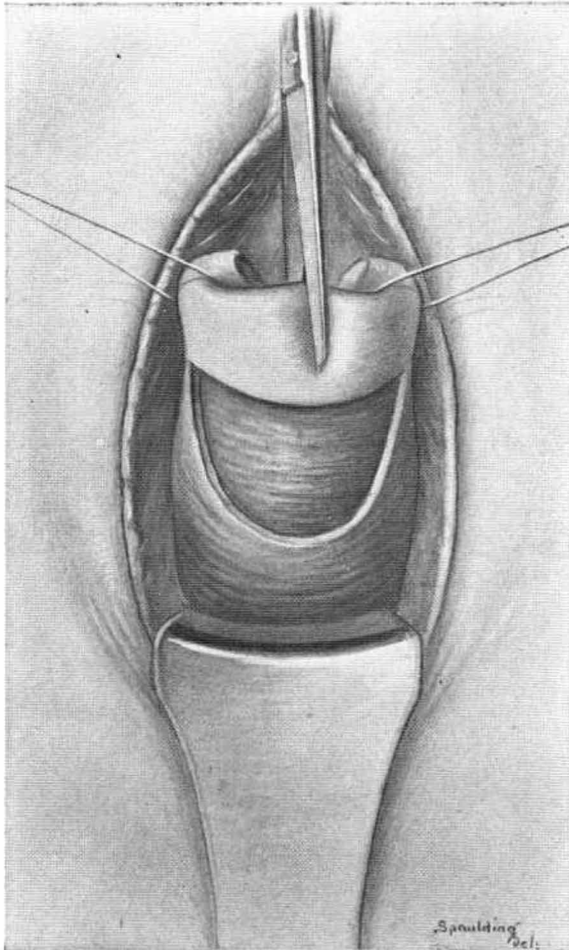

Fig. 3.—The posterior lip of the cervix is pulled upward toward the symphysis. A transverse incision is made at the junction of the vagina and cervix. The posterior culdesac and the rectum are reflected downward, and the posterior lip is incised as far up as possible, care being taken to respect the abdominal cavity.

tumor in question, or even hysterectomy in the case of multiple myomas. In cervical carcinoma, if the extension of the lesion is limited, and the patient is in good physical condition, delivery should be accomplished by the abdominal route and followed by the total extirpation of the uterus and its adnexa. In the more advanced cases de-

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livery by a fundal cesarean section followed by implantation of radium in the cervix and by deep x-ray therapy may prove to be the most successful method. The frequent extension of the neoplasm toward the bladder will complicate the separation of the vesicouterine culdesac and present the risk of incising a lower segment which is edematous, infiltrated, inelastic, and which does not furnish the passage that is necessary for a successful delivery.

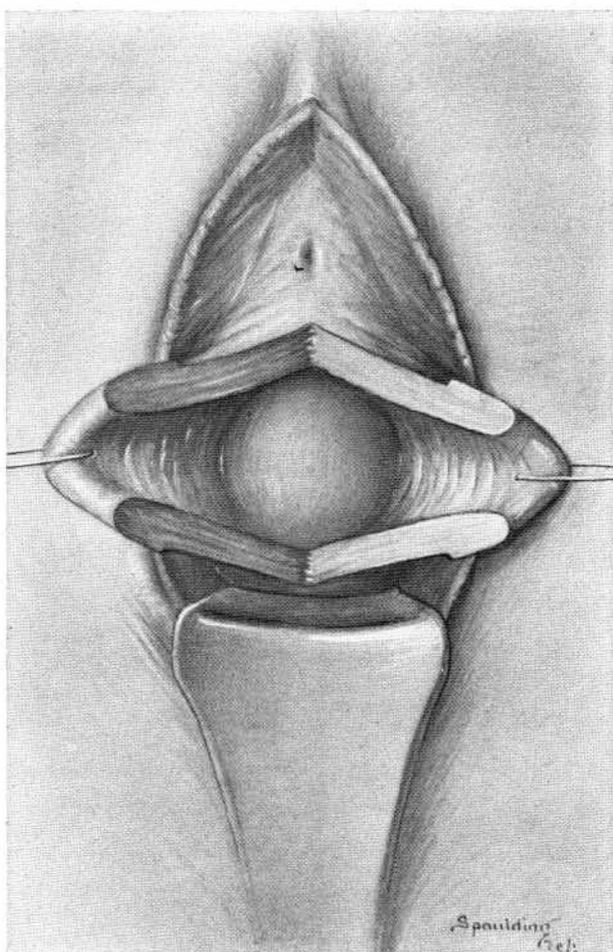

Fig. 4.—Anterior and posterior cervical incisions have been made. The delivery and extraction of the placenta and membranes follows.

Group II.—Lesions of the heart, lungs, and kidneys are still looked upon as suitable indications. As far as eclampsia is concerned, opinions are divided, but most obstetricians, nowadays, favor the Stroganoff conservative treatment or some modification of it, rather than the emptying of the uterus during convulsions. The vaginal cesarean section, nevertheless, is of marked value in the toxemic pa-

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3. Pernicious vomiting of pregnancy in a gravida who is dehydrated and exhausted and who would not stand a long labor.

4. Premature separation of the normally inserted placenta in its milder forms.

TECHNIC OF OPERATION

A weighted speculum is introduced in the vagina to expose the cervix. The cervix is brought down by means of two volsellas, one at each lateral angle, and dilated with Hegar dilators to assure drainage. A suture of chromic catgut is placed at each lateral angle of the cervix and left long. These sutures facilitate the bringing down of the cervix after delivery. If the cervix is not readily brought down by this method, a No. 4 Vorhees' bag is introduced into the uterus; it is filled with 1 per cent lysol solution, and is used as a tractor. A transverse incision is made in the anterior vaginal wall at the point of attachment of the bladder to the cervix, and the bladder together with the vaginal wall is dissected upward to the reflection of the anterior peritoneal culdesac. The bladder is never separated from the vaginal wall, as is illustrated in most textbooks, because this has been found unnecessary and predisposes to bleeding and injury to the hyperemic and friable vaginal wall.

The bladder is now held under the symphysis by means of a wide retractor, and the anterior lip of the cervix is incised up to the vesicouterine culdesac, care being taken not to enter the peritoneal cavity. The posterior lip of the cervix is pulled upward toward the symphysis, with volsella or the bag, as the case may be, and a transverse incision is made at the junction of the vagina and the cervix. The posterior culdesac and the rectum are reflected downward, and the posterior lip is incised as far up as possible, care being taken to respect the abdominal cavity.

The instruments are now removed and the hand is introduced into the uterus, an internal podalic version and a breech extraction are performed in the usual way, and the placenta and membranes are extracted manually. By injecting pituitary extract and an aseptic preparation of ergot, the bleeding is usually controlled, so that packing is rarely necessary.

The cervical incisions are closed with interrupted sutures of No. 2 chromic catgut; the vaginal incisions are sutured in the same manner with the same material.

When the fetus is small, it is not necessary to incise the cervix posteriorly, as the anterior incision usually gives enough room for its extraction.

AUTHOR'S SERIES OF VAGINAL CESAREAN SECTIONS

TABLE I. NUMBER OF PREGNANCIES

Para i	17	
Para ii	2	
Para iii	5	
Para iv	2	
Para v	1	
Total		27

TABLE II. PERIOD OF GESTATION

Full Term	1	
8 months	4	
7½ months	3	
7 months	11	
6½ months	4	
6 months	1	
5½ months	1	
5 months	1	
4 months	1	
Total		27

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CONCLUSIONS

1. Vaginal cesarean section is a useful operation when an indication for immediate delivery arises in a gravida with a long, rigid, undilated cervix, up to the end of the eighth month of gestation.

2. The operation may be done at term, as shown by one of the cases of this series; but here the difficulties are greater, and there is danger of the incisions tearing in the peritoneal cavity because of the large size of the child.

3. A previous low cervical cesarean section complicates the technic of the operation, since the anterior peritoneal culdesac has been obliterated. This may predispose to injury to the bladder during delivery.

4. Since the operation is extraperitoneal, postoperative complications are negligible.

5. The puerperium, as a whole, resembles that of any operative pelvic delivery.

6. The low transperitoneal abdominal cervical cesarean section which offers nearly as much protection against infection as does the vaginal hysterectomy has displaced the latter operation in a number of clinics because of its simpler technic.

270 Commonwealth Avenue.

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