THREE CASES OF RUPTURED PERINÆUM.

By RICHARD J. KINKEAD, M.D., L.R.C.S.;

Lecturer on Medical Jurisprudence ;

Professor of Obstetric Medicine, Queen's College, Galway.

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So clear are the indications, so positive are the advantages of the operation, that, at the present day, to advocate the immediate repair of a recently lacerated perinæum would seem to be a work of supererogation, and to need an apology.

To those who hold that puerperal fever is in its origin solely septicæmic, the shutting of a facile door of entrance against the omnipresent, diabolically active, and poisonously powerful bacteria is positive proof of the absolute necessity of the operation, and that omitting the immediate suture of a lacerated perinæum is little less than culpable negligence.

To those whose faith in bacteria is weak, as well as to those who, although firm believers in their insinuating ingenuity for evil, yet think that puerperal fevers may be—nay more, not unfrequently are—produced from other than septic sources, the success which has followed insertion of sutures immediately after labour, thereby avoiding the danger and disagreeability of a secondary operation, has, or ought to have, been sufficient to make them adopt the operation as an imperative obligation.

Yet, and with all, the obligation is frequently neglected, and we find patients turning up from time to time suffering from the evil effects of unrepaired perineal lacerations.

Perhaps the neglect to repair arises principally from two causes :—

1st. The notion—which overlooks altogether the danger of septic infection from a raw surface—that if the laceration is not extensive it is needless to suture, inasmuch as union may, and probably will,

take place by means of rest, position, and cleanliness; that if it does not no great harm is done; whereas, on the other hand, if the laceration is extensive, more especially when the rectum is involved, suturing the wound is useless, for union is not likely to follow.

2nd. That laceration of the perinæum is an indication of incompetence, or neglect, likely to prejudice the patient against the practitioner; that if nothing is done, the fact of laceration having taken place will probably escape observation; whereas, by inserting sutures attention is called to the injury. That, therefore, it is wiser not to suture, more especially as practitioners still bear in mind the comfortable words of the old masters—that union usually takes place from apposition of the legs.

I cannot help thinking that laceration depends more on the quality of the perinæum itself and the size of the foetal head than on the rapidity of delivery or method of support.

One meets cases in which the perinæum has the elasticity of Indian rubber, in which it yields handsomely to the strain, be it ever so great; others of that rigidity and obstinacy that, oak-like, they break, but will not bend; and others, again, that, on the slightest provocation, tear like pieces of brown paper.

In the first class, the practitioner gives himself the credit due to the perinæum, and flatters himself that his judiciously applied support, or scientific relaxation, has prevented laceration; in the second class, a tear may be avoided by incising the free margins; but in the last, nothing that can be done shall preserve the perinæum unturned.

Whether it be that higher education and social progress produce larger foetal heads or render the perinæum more friable, this deponent sayeth not; but certainly I now find it more difficult to preserve the perinæum intact than I used to when I began to practise; and I think that when ordinary precautions are taken practitioners should not be considered in fault if laceration occurs. When, however, it does happen, then I am convinced that it ought to be dealt with like any other wound, and sutured at once.

As the strongest argument which can be used in favour of any

procedure is its simplicity and its success, I venture to trespass on the forbearance of the Section with the history of three cases of ruptured perinæum; for, although to the members it may appear like again slaying the dead, to others who may still be doubtful it offers proof of the benefits of the practice.

They are further interesting from the fact that each is illustrative of a degree of laceration, and one is specially so from the size of the child's head, and from the injury to it inflicted during labour, from which, however, it completely recovered.

CASE I.—Mrs. X., aged forty-two, or thereabouts, was taken in labour, at term, of her first child; presentation vertex L. O. A.; infant a female; pelvis normal and roomy, except that coccyx was ankylosed and somewhat projecting. Labour proceeded with fair rapidity until the head reached the projecting coccyx. After waiting a reasonable time, and finding that, although the uterine contractions were strong, neither the head advanced nor the coccyx yielded—the patient being fully under chloroform—I applied the forceps. Notwithstanding support *secundum artem*, and great care in extracting, the perinæum tore down to margin of the sphincter. The placenta was expelled in about five minutes, after which two sutures were inserted.

The wound healed by the first intention, and the puerperal period was normal throughout.

CASE II.—Mrs. T. was also, quâ child-bearing, well stricken in years. She had been twice married. For the twelve years during which her first matrimonial life had continued she had been barren, and now, eighteen months after her second marriage, she was in labour with her first child. Verily, as to its size, she had made up for lost time with a vengeance. She was under the care of a nurse, and I had been sent for, as, after many hours, there was no advance.

The patient was a well-made, healthy woman, with a normal pelvis. The pains were rapid, and, though short in duration, strong. The perinæum was moderately distended; on separating the labia, the vextex could be seen slightly protruding at the vaginal orifice, in which position, the nurse asserted, it had been for two or three hours; it neither advanced during the pain nor receded in the interval.

I put on Simpson's long forceps at once, expecting to have very little trouble with a head so apparently nearly born; but instead of the head extending the forceps came away with a run, the tips of the blades striking and nicking the perineal margin at each side of the raphe.

Abdominal palpation and rectal examination showed the bulk of the head to be above the brim, and the presence of the vertex at the vaginal orifice to be due to enormous elongation of the head.

I again applied the forceps, and found it necessary to make traction in the axis of the brim, the head remaining motionless, and the blades slipping with any attempt at extension. As the head gradually descended the perinæum was enormously distended. As the head came down the grip of the forceps lessened. It was impossible to get them any higher, so I passed two fingers into the rectum, and thus gradually drew the head on. So elongated was the vertex, so large the head, that when the ends of the forceps on the parietal bones were clear of the vulva the tips of the fingers in the rectum just touched the orbits.

Although extraction was exceedingly slow, and although the perinæum was drawn as well forward as possible, laceration could not be prevented. Starting from each nick caused by the blades of the forceps, it gradually tore backwards and outwards at each side as the head progressed, until, when the child was born, the lacerations extended as far back as the posterior margin of the anal aperture. The rectum was not injured, nor the sphincter torn, the rents having apparently travelled around its border: in the centre was a triangular piece of perinæum, and the wound, looked at from behind, was of the shape of a capital W.

After delivery of placenta, I inserted four sutures passed deep into tissues and through the central portion. Four-fifths of the extent of laceration healed by the first intention, the apex of the central portion alone suppurating: the puerperal period was normal.

The child was well developed and healthy, but very large; the head was the largest I have met with. When applied as far as they could go the tips of the forceps only reached the middle of the parietal bones.

The left temporal bone was fractured, not by the forceps, for they did not get so high, but by pressure against the promontory of the sacrum. There was an enormous bloody tumour over the occipital bone, and for months the infant was hemiplegic (right).

He gradually has recovered the power in the right side, and

now, at three and a half years of age, he looks perfectly healthy. He is well grown for his age; his intellectual powers are quite equal to those of other children; and any deficiency of power in the right side is only remarked by a decided tendency to be left-handed and left-footed.

CASE III.—Was a primipara, aged twenty-two. The first stage was tedious; the second very rapid. As the head advanced quickly I urged the patient not to strain, and exhorted her to cry out—all to no purpose. As the head touched the perinæum she seemed to lose all control, and, as if compelled to strain, with one vigorous effort shot the child clear out of the vulva at least six inches from her on to the bed. There was no pause as the head was born; no pause for rotation; no gradual expulsion of the shoulders. As the head cleared the orifice of the vagina, rotating as it came, the liquor amnii were ejected, as if from the hose of a fire-engine, clean over the foot of the bed, while the shoulder was driven like a plough-share through the perinæum. The laceration extended into the anus, and for an inch up the rectum.

A suture passed from behind forward and through the sphincter, entering somewhat behind the diameter of the anal orifice, and passing in front of the torn bowel, to emerge on the other side opposite its point of entrance, brought the edges of the wound in both rectum and anus into handsome apposition. Two other sutures repaired the rest of the rent.

The puerperal period was normal throughout, and the wound healed by the first intention.