TECHNICAL MEMORANDA, OPERATIVE AND OTHERWISE.

(Under this heading will be published from time to time notes on points of practical interest in regard to methods of treatment, operative and therapeutic, and on the general management of Obstetrical and Gynæcological cases in hospital and private practice.)

Operation in Cases of Complete Prolapse.

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Preliminary treatment.

If the vaginal walls and cervix are ulcerated as the result of being exposed to friction, preparatory treatment is necessary. The prolapse is reduced, the patient is kept in bed, and frequent vaginal douching—with some weak antiseptic—is employed.

Operation—preliminary.

If there is reason to believe that there is endometritis or chronic metritis, the uterus is curetted. If the cervix is lacerated or hypertrophied a plastic operation is performed—which generally takes the form of excision of a wedge from each lip, anterior and posterior, of the cervix.

Anterior colporrhaphy.

The anterior lip of the cervix is seized with vulsellum forceps, and the anterior vaginal wall put on the stretch. A triangular flap is then marked out—the apex being close to the cervix and the base on a level with the vaginal outlet—generally about $\frac{1}{2}$ inch from the urethral orifice. The breadth of the base of the triangle varies with the volume of the prolapsed mass, but in a bad case measures from $2\frac{1}{2}$ to 3 inches. The flap is then dissected off. If the right layer is reached the dissection is easy, in fact the separation may be largely accomplished by pulling on the flap and pushing with the index finger in the layer between vaginal mucous membrane and bladder. The whole flap is removed. Stitching with, interrupted catgut, is then begun from the apex of the triangle, which is the lowest point when the uterus is prolapsed and the vaginal walls inverted. The stitches go from mucous membrane to mucous membrane, and do not pick up any of the raw surface, unless for the purpose of underrunning a bleeding point. After the first few stitches have been introduced, the prolapse is reduced and the remainder of the operation performed with the parts in their normal position. Each stitch after it is tied is left long and used as a means of traction until another one has been introduced and tied, and then is cut short.

Posterior colporrhaphy.

With the parts in their normal position a vulsellum forceps is introduced into the vagina, and the posterior wall seized as high up as possible, and in the middle line. If it is impossible to reach very high in this way, the highest advisable point may be reached by pulling on the first vulsellum and catching a point higher up with a second forceps—when the first one is removed,—even a third vulsellum may have to be used in this way. Having got as high up as possible in the middle line, two Spencer Wells' forceps are fixed to the vaginal mucous membrane, each a little lower than the vulsellum and a little outside the middle line. A small triangle is thus mapped out (when the forceps are pulled in different directions) high up on the posterior wall. The flap thus marked out is dissected off, beginning with the apex (the highest point), but the base of the triangular flap is not divided—a forceps is attached to the apex of the flap and is allowed to hang down,—the raw surface of the flap therefore faces the operator. The two sides of the incomplete triangle are brought together by interrupted catgut, just as in the case of the anterior colporrhaphy. When the stitching has been done as far as the sides of the triangle extend, the Spencer Wells' forceps are removed and attached each to a point lower down on the vaginal wall and further out from the middle line. The two sides of the triangle are then continued by division of the mucous membrane from the points where they terminated to the forceps, and the flap is detached to the level of the forceps. The stitching is then proceeded with. A point of importance is always to use the last stitch as a tractor, and never to cut it short until another one has been put in and tied. As the dissection gets lower in the vaginal wall, the sides of the triangle naturally diverge. When the vaginal outlet is reached, the divergence is marked. As a rule each side incision terminates at a point midway between the vestibule and the fourchette. The greater the divergence of the sides of the triangle the more marked is the subsequent narrowing. The whole flap is removed in its entirety by dividing the base by an incision which runs round the posterior part of the vagina at its junction with the skin of the perineum.

At the lower portion of the raw surface the stitches are inserted differently—some stage stitches are inserted—that is, some portions of the raw tissue are picked up and approximated from side to side and the ligature cut short so that is eventually buried when the edges of mucous membrane are brought together. The final stage is reached by putting some silkworm gut stitches in the skin of the perineum.

I am much indebted to Dr. W. E. Fothergill for the accompanying diagrams. They were drawn during the performance of the operation.

Fig. 5. Posterior wall. Further dissection of flap. The new vagina is shown above uncut stitch.

Fig. 6. Completion of raw surface in posterior wall.

Fig. 7. Buried sutures in posterior wall and perineum tied. Other sutures inserted.