FRENCH SUPPLEMENT TO THE LANCET

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METHODS OF HYSTERECTOMY.

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WHEN the surgeon takes up his bistoury to perform abdominal hysterectomy for fibromyoma of the uterus or salpingo-ovaritis he cannot know beforehand what procedure he will adopt. If the cervix uteri is so affected that ablation appears to be necessary, he will perform total hysterectomy. The cervix uteri can usually be conserved, and its conservation holds more advantages than inconveniences. Subtotal hysterectomy is, in the opinion of J. L. Faure, the routine operation, established by 25 years of gynæcological surgery. Total hysterectomy remains an exceptional operation; in difficult cases it is advantageous first to perform the subtotal operation, and thus, when the pelvis is largely emptied, to remove the cervix, thus converting subtotal into total hysterectomy.

Only after the abdomen is opened, when the lesions are apparent, can the surgeon select his operation; his choice must be made in a few seconds of time and is of capital importance. It must be remembered that personal habit is to be considered; such and such a procedure, excellent under some anatomical conditions, becomes difficult and impracticable under others.

There are several guiding principles of use in assisting a judicious choice.

1. To discover the uterus amidst the lesions which obstruct the false pelvis, the first task is to separate the intestinal and epiploic adhesions and to disengage the fundus uteri; only when this preparatory work is finished can the attack on the utero-adnexal lesions be attacked.

2. To deal with the easier side first, leaving the more septic and more dangerous lesions until last.

3. Removal of the adherent adnexal mass must be done from the inner side and from below. Separation of adhesions at the lateral wall of the pelvis is a difficult and dangerous undertaking if begun from the external side and carried out from above downwards. It is made singularly easier if, after having found the inferior pole of the ovaro-salpingitic mass, the operator works from below upwards.

4. When traction is applied to the uterus, that organ is only held in place by the cervix and its connexions with the vagina. Once the cervix is divided, the uterus may be withdrawn, and the pelvic cavity thus relieved. In difficult cases it is therefore well to perform section of the cervix as soon as possible during the operation.

To sum up—the surgeon should follow the shortest and least obstructed route to reach and perform section upon the cervix uteri in order to deal with the lower pole of the adnexal masses. As this shortest and least obstructed way is not always the same, different procedures are necessary according to circumstances. The whole art of the operator is to know how to adapt his method of attack to the lesions met with, and to employ the procedure most suited to the case in hand.

In easy cases all methods are suitable. H. A. Kelly's operation (Fig. 1), still described as the "American method," is one of those most used; the less affected side is first taken, and after section of the cervix the thick utero-adnexal mass is approached at its lower extremity and separated from below upwards. This is the method of choice for double salpingitis with a large unilateral adnexal mass. In fibromas without salpingitis,

or with a slight form of salpingitis, Kelly's method is again preferable. As soon as possible after division of the cervix the uterus is drawn aside, leaving space to secure and cut the second uterine artery and easily to separate the adherent adnexa from below upwards.

Amongst operations suitable for easy cases, that of posterior decollation (J. L. Faure's method) (Fig. 2) is particularly rapid. In this procedure, the uterus is drawn forward and its posterior surface displayed; the isthmus portion of the cervix is severed with curved scissors from behind forwards. The uterus is then raised, the uterine arteries are cut, and the finger is inserted through the breach in the broad ligament to separate the corresponding adnexa. When inflamed adnexa are very adherent to the pelvic wall, but leave the edge of the uterus free, it is useful to perform section of the broad ligament between the adnexa and the uterus; this is Terrier's method—in such a case the most direct way of approach for division of the cervix. The uterus is first raised, and through the breach thus made the adnexal masses are successively dealt with.

In other cases, the adnexa on one side are found to have adhesions in every direction, whilst the other, less voluminous, adhere to the pelvic wall and prevent the use of Kelly's method, but leave between themselves and the uterus sufficient space to admit of performance of the first stage of Terrier's operation. (Fig. 3.) The only available route to the cervix is then employed; the latter is cut and the adnexa on that side raised, together with the uterus, to which they are adherent. This combined Kelly-Terrier's method of operation is concluded by simple ablation of the remaining adnexa.

Turning now to lesions still more pronounced—adnexal masses on both sides, adherent to the pelvic wall and to the uterus, so that it is impossible to pass round or behind them—what is to be done? Faure's method must be followed, and the incision made at the centre of the uterus, the operation of hysterectomy by uterine hemisection. (Fig. 4.) The fundus uteri being recognised and secured by two traction forceps, the uterine cavity is laid open by an exactly median incision with scissors, section being prolonged to the isthmus. The first half of the cervix is transversely divided, the uterine artery being secured and the adnexa separated according to routine; the other half of the uterus is then removed in the same way. For hemisection to be possible, the posterior face of the uterine body must be free or easily liberated. If this face be covered by the adnexal mass and unapproachable—an exceptional state of affairs—anterior decollation still remains to the operator's hand. (Fig. 5.)

It is very seldom that the vesico-uterine peritoneal cul-de-sac is not free; when free it permits sight of the isthmus portion of the cervix, which is cut by the scissors from before backwards, division being performed in sight. Division of the cervix completed, the way to the base of the broad ligaments lies open, and after section of the uterine arteries separation of the adnexal masses may be proceeded with.

In certain exceptionally difficult cases, the uterus is fixed in retroversion and retroflexion in the midst of the adherent masses. In order to disengage the organ, anterior decollation (Fig. 6) can be employed, and then hemisection (from below upwards) of the cervix already transversely divided towards the fundus uteri. By following round the uterine cavity the operator retains an excellent guide, permitting enlargement of

DIAGRAMS ILLUSTRATING VARIOUS METHODS OF HYSTERECTOMY.

FIG. 1.—H. A. Kelly's method, admitting of approach, from behind and below, the most adherent form of adnexitis, thereby facilitating its decollation.

FIG. 2.—J. L. Faure's method of posterior decollation. When the cervix uteri is dissected the uterus can be removed and access gained to the adnexal mass.

FIG. 3.—Combined Kelly-Terrier method. The cervix is reached through the space between the left adnexa and the uterus. After section it becomes possible to approach from below the right adnexa, presumably very adherent in all directions. The operation is terminated by separate removal of the left adnexa.

FIG. 4.—J. L. Faure's method of hemisection. As the adnexa completely fill the space between uterus and pelvic wall, median section of the uterus allows the cervix to be reached and dissected in order to approach the adnexa in turn.

FIG. 5.—J. L. Faure's method of anterior decollation. As the uterus is in retroversion, the fundus being completely masked by adherent adnexal masses, the first section of the cervix permits recognition and compression of the uterine arteries, and then approach to the adnexa from below.

FIG. 6.—J. L. Faure's method of retrograde decollation and hemisection. After section of the cervix the uterus cannot be separated from the pouch of Douglas; hemisection, following the uterine cavity, is without danger and facilitates liberation of uterus and adnexa.

the route of approach without any risk. This method is described as anterior decollation with retrograde hemisection.

Lastly, there is the condition where the positions of lesions are supremely inconvenient for the operator—fibromyoma of the uterus, blocked in the pelvic cavity by a double salpingitis adherent in all directions. In this case, hemisection cannot be performed; anterior decollation is also impossible because the cervix uteri is not approachable from in front—between the fibroma and the bladder (crowded against the os pubis) there is not room to use the scissors. Evidently by morcellation must be performed, and as the fibromatous masses are removed, the pelvis will become less congested. The region of the cervix uteri is finally reached, and the operation is concluded as in hysterectomy by hemisection. This method of *évidement* is that of Professor P. Bégouin of Bordeaux.

SUBTOTAL HYSTERECTOMY:

FAURE'S OPERATIONS OF HEMISECTION AND DECOLLATION.

BY E. DOUAY.

1. *Hysterectomy by Hemisection.*

HEMISECTION is the most remarkable of the less common operations of hysterectomy. It was performed for the first time by J. L. Faure in September, 1897, and is now practised throughout the world; there are even surgeons who wish to extend its indication to all cases of hysterectomy for double salpingitis, but it must remain an exceptional procedure, of considerable value in exceptional cases. The operation is indicated chiefly in bilateral salpingitis, with double adhesions to the pelvic wall on one side and to