Method of Suture of the Uterine Wound in Cæsarean Section.

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WHILE it is probable that faulty union of the uterine scar is due in a large majority of cases neither to the material used for suture nor to the method employed, but rather to infection, it is important that the technique of suturing should be as scientifically perfect as possible. The suture-material should, therefore, be slowly absorbable, and the sutures should be placed so as to be effective in securely approximating all parts of the thick muscle wall.

Tanned catgut will do all that silk can do in the matter of keeping the surfaces of the wound together until healing has been secured, and this material will not act as a nidus for organisms for any length of time, as may silk. I do not think this point is open to dispute in view of what has happened in connexion with the use of silk in other operations.

In regard to the closure of the wound accurate apposition of all parts must be secured. Some operators employ continuous sutures in several layers. This seems to me to increase the risk of subsequent gaping of the wound when retraction takes place; and the use of ordinary interrupted sutures does not prevent separation of the wound between the stitches (fig. 1).

FIG. 1.

Gaping of uterine incision that may follow the use of interrupted sutures.
Viewed from above.

A combination of both procedures should be safe, but it is unnecessarily complicated.

Since 1912 I have practised the following method of suture. It is one which I have for many years employed in procedures other than Cæsarean section. A Reverdin needle-holder with a *large* curved needle is used, and mattress-sutures are placed through the whole depth of the musculature on either side at close intervals throughout the entire length of the wound. The ends of these are left untied until the last has been passed when they are all knotted just tightly enough to bring the deeper parts in close contact (fig. 2).

FIG. 2.

Mattress-sutures for closure of deep muscular layers of uterine incision
Viewed from above.

The ends are left uncut, for the next stage consists of the closure of the now V-shaped superficial area. This is effected by using the long uncut ends of the mattress sutures which are brought through and over the superficial parts of the wound by means of the Reverdin needle, and again tied (fig. 3).

FIG. 3.

Overstitch for closure of superficial layers of musculature of uterine incision. Viewed from above.

FIG. 4.

Buttress appearance of sutured uterine incision when viewed from the side and from above.

The final peritoneal suture is almost complete.

Last, the peritoneal edges of the incision are held together by means of a continuous suture of fine plain catgut (fig. 4).

I have practised this procedure, which I described in the discussion on Cæsarean section at the Royal Society of Medicine in 1920,¹ in between thirty and forty cases, some of which have been submitted to subsequent Cæsarean section, when it has been difficult or impossible to find the site of the uterine wound previously inflicted.

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