

PERINEOTOMY.

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FOR more than a year I have endeavored to satisfy myself of the feasibility of gaining access to certain pelvic organs through the perinæum. Up to this time I had occasion to conduct my experiments only on the cadaver, and I would, not appear before the profession with the results of my studies unless the investigations of Zuckerkandl and Wæßler, and the discussion in the Third Congress of German Gynecologists had brought the subject into prominent notice,

The name "Perineotomy," proposed by Sænger, is given to an operation which includes an incision through the whole or part of the perinæum in order to gain access to the organs situated above it. It is, therefore, evident that the incision may vary in size and shape, just as the special object of the operation may vary. It is true that similar procedures have been followed as a part of other operations, as, for example, in extirpation of the rectum, or in Tait's flap-perineorrhaphy, but what more particularly is claimed for it is the dignity of a method *per se*, when followed in a premeditated manner.

In regard to the history of the operation; it seems to me that Hegar deserves the credit of priority from having used it for evacuating pelvic abscesses. Sænger operated by perineotomy to remove a dermoid cyst from the subperitoneal space. Frommel followed the method in several cases of total extirpation of the uterus, when the vaginal method seemed unavailable, of course, after freeing the cervix from the vagina. Zuckerkandl and Wæßler have given the subject a new impetus

and, no doubt, others will soon be heard from. The various operations, as I find them described, are :

1. Zuckerkandl's.—Right lateral position; incision on left side, beginning at the tuberositas ilii and carried along, parallel with the side of the sacrum, in a curved line, ending between the tuberosity of the ischium and the anus. The gluteus maximus, the ileo and spinoso-sacral ligaments, the coccygeus muscle, and, perhaps, part of the levator ani, are severed from their attachments to the sacrum and ischium, or divided. This cut exposes the extraperitoneal part of the rectum in its whole extent. By proceeding toward Douglas' cul-de-sac, an easy matter in the large wound, division of the peritoncum brings to view the pelvic organs, including the upper part of the rectum, the sigmoid flexure, and the uterus with its appendages.

2. Wœlfser's para-sacral incision. This begins at the third sacral vertebra and ends beside the anus. Wœlfser prefers the left lateral position and right side incision.

3. Frommel's (on women only) incision from one tuber ischii to the other,; separation of vagina and rectum.

4. Sænger makes the incision in the sagittal direction, beginning at either labium majus and ending 2 cm. beyond the anus. This opens up the ischia-rectal and subperitoneal spaces,

5. Hegar makes his incision from the tuber ischii to the tip of the coccyx.

All these authors emphasize the simplicity of the operation and the perfection in which the parts to be attacked are brought into view.

In my own experiments I used male bodies only. Lithotomy position; sound in the bladder, held by an assistant. Whilst now the left index finger from the inside and the thumb from the outside firmly hold the sphincters of the rectum, the incision is made right above the thumb across the perinaeum from one tuber ischii to the other. In the further detachment of the rectum, the handle and the finger nail has to be used as much as possible. The rectum can rapidly be separated from the prostate and the bladder, and the recto-vesical fold exposed. It is remarkable how simple the operation is, and

how superficial the parts appear. The subperitoneal part of the rectum, the prostate, the posterior wall of the bladder are all in sight. Less apparent are the ureters, the seminal vesicles and the seminal cords. After dividing the recto-vesical fold there is ample room for access to the peritoneal cavity.

Among the operations feasible by this method, I mention the following :

On the Rectum.—Removal of the subperitoneal portion; after dividing the peritoneum, also of the intraperitoneal portion and of the sigmoid flexure. Kraske's resection of the sacrum is made unnecessary. Recto-vesical fistula can be closed in both organs after dedoublement.

On the Prostate.—Resection or total removal.

On the Bladder.—Removal of stones and—before all—of tumors in the trigonum and base. Permanent drainage can be established with greater advantage and more comfort than in any other way.

The *ureters*, although not so readily discovered in my experiments, can be made accessible; constrictions, bending, compression relieved, and their permeability tested. Perhaps, also, the ureters would be temporarily compressed, in order to test the urine from the two kidneys separately.

The *seminal vesicals* and *cords* are hard to find. Still, it may be that we have here the field for a new specialty.

In the female the operation will be useful for removing subperitoneal tumors; for extirpation of the uterus, opening of sub- or intraperitoneal abscesses, also for drainage of the peritoneal cavity, etc. Though perineotomy will, as a rule, not be able to compete in strict gynecology with laparotomy, it will nevertheless under circumstances be a valuable complement to it. In the male, however, there is no doubt in my mind that this new operation will prove a very useful acquisition.

There is nothing to be said against it, unless, perhaps, the danger of opening a great number of large veins, but experience as acquired in other peritoneal operations, dismisses sufficiently such objections.

As to the relative advantages of the various incisions, uni- or bilateral, sagittal or transverse, we are not yet in a position

to dogmatize. Evidently the incision should be made to suit the requirements of the case, when the indications are clear. In doubtful cases and in all those in which the rectum, the prostate or the bladder are attacked, the transverse bilateral incision, as made in my experiments, will be the one giving the greatest satisfaction.