

SELECT CLINICAL REPORTS.

(Under this heading are recorded, singly or in groups, cases to which a special interest attaches either from their unusual character or from being, in a special sense, typical examples of their class.)

An Operation for Prolapse Complicated by Hypertrophy of the Cervix.

By W. E. FOTHERGILL, M.A., B.Sc., M.D.

WHEN prolapse is complicated by hypertrophy of the cervix it is usual to begin the operation for its relief by removing a proper portion of the cervix and suturing the wound thus made in the customary way. Then a fresh incision is made and an anterior colporrhaphy is performed. But if the anterior wall is excised at all freely, the two incisions approach one another closely and a very poor and narrow bridge of sound tissue is left between them. Further, the amputation of the cervix tends to shorten the anterior vaginal wall, and thus, when the colporrhaphy has been completed,

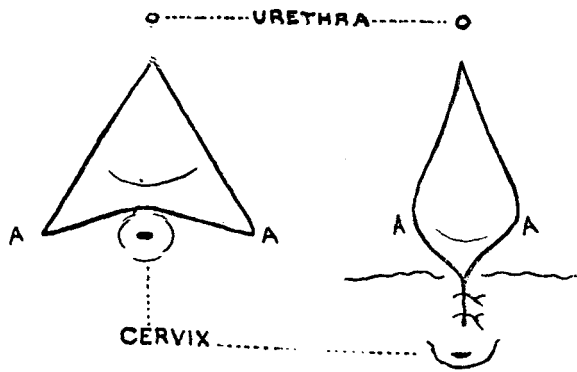


Fig. 1. Colporrhaphy incision for prolapse without hypertrophy of cervix.

the cervix still points downwards and forwards and the uterus is left in a position of retroversion which is very favourable to the recurrence of prolapse. For some time past I have been using a single incision for both the amputation of the cervix and the excision of the redundant vaginal wall; and have found the results more satisfactory than those obtained by doing the operations separately. In order to make clear this modification of technique it is necessary to explain

how I treat ordinary cases of prolapse in which the cervix is not hypertrophied. The anterior colporrhaphy is done so that the wound is broad above and narrows to a point near the urethral orifice. The piece of vaginal wall removed is roughly an equilateral triangle with its base touching the cervix and its apex near the urethral orifice. The easiest way of making the incision is to pull down the cervix with a vulsellum fixed in its anterior lip and then to pick up with forceps two points about three inches apart, one directly to the right the other directly to the left of the *os uteri*. The vaginal wall is put on the stretch and is cut through between the tips of the instruments. It is then easily separated from the bladder and a triangular portion is cut away.

This extension of the wound into the lateral vaginal fornices exposes the connective tissue on either side of the cervix—the *parametria*. When the wound is closed from side to side the tissues which previously lay at the sides of the cervix are united in the middle line in front of the cervix. This manœuvre pushes the cervix back towards the hollow of the sacrum and thus tilts the fundus forward into a position of anteversion. The suturing of the wound begins at the cervical end of the wound, for as the stitches are tied one after another, this end of the incision with the cervix behind it disappears from sight and, if the incision is broad enough, is not seen again. The closing of the lower part of the wound corrects the cystocele, and thus anterior colporrhaphy done as above described remedies both the retroversion and the cystocele whose combination is characteristic of classical prolapse. The catgut used for the sutures is hardened with formalin or chromic acid sufficiently to last for about three weeks. Interrupted sutures are used. For if a continuous suture or even a series of mattress sutures is used the incision is shortened, and thus the cervix is pulled downwards and forwards. This reproduces the retroverted position of the uterus and favours recurrence of the prolapse.

To complete the operation, the vaginal outlet is narrowed by repairing the perineum. The upper part of the posterior vaginal wall is not touched.

The modification of this operation which I have been using in cases of prolapse complicated by considerable elongation of the cervix is as follows. The cervical canal is dilated and a circular incision is made round the cervix with a knife. The vaginal wall, the bladder and the parametria are then snipped free with scissors and pushed back from the cervix. The vaginal wall is next incised for an inch or so on either side of the circular incision already made, the new cuts extending directly to the right and to the left. The anterior vaginal wall is now separated from the parametric tissues and from the bladder, and a triangular portion with its apex near the urethral aperture is cut away. The cervix is next amputated,

enough being cut away to leave the uterus three inches long. The stump of the cervix is now stitched into the posterior part of the incision. The first suture brings together the central point of the posterior limb of the vaginal incision and the mucosa lining the posterior wall of the cervical canal. The second and third stitches unite vaginal wall and cervical mucosa right and left of the first. And so on, until the sides of the vaginal incision come together in front of the stump of the cervix. By this time the newly constructed os is beginning to disappear upwards and backwards. The lateral edges of the vaginal wound with the subjacent connective tissue are brought together in the middle line from behind forwards. The line of suture disappears from view as the later sutures are tied. The perineum is finally repaired as before.

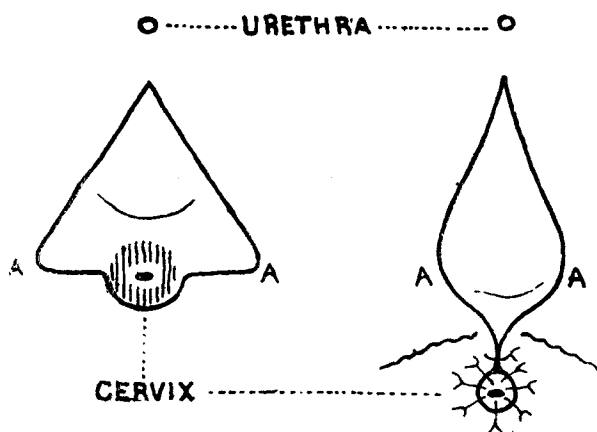


Fig. 2. Incision for amputation of cervix and colporrhaphy in prolapse with hypertrophy of cervix.

I find this method of operating convenient both when the elongation of the cervix is mainly supra-vaginal and also when the elongation mainly affects the vaginal portion.

In connection with this subject I should like to express complete scepticism as to the existence of the so-called tensile elongation of the cervix, which was supposed to be produced by the dragging upon the cervix of prolapsed vaginal walls. Such a thing occasionally occurs after the uterus has been fixed to the abdominal wall by a ventrofixation. But if the uterus is not fixed above how can it be lengthened by pulling on it below? The theory of elongation by stretching seems to be a relic of the times when the uterus was thought to be held up by the broad and round ligaments. Now that the cervix is well known to be the most firmly attached portion of the uterus, surely the theory of tensile elongation may be allowed to drop gently into oblivion.