* SOME OBSERVATIONS ON VAGINAL CELIOTOMY

By SAMUEL W. BANDLER, M.D.

Adjunct Professor of Gynaecology, New York, Post-Graduate Medical School and Hospital

Vaginal celiotomy, which includes the anterior and posterior methods, has of necessity been practised for many years in the performance of vaginal hysterectomy. Anterior vaginal celiotomy first gained its real dgnity when Mackenrodt and Dührssen began to perform vaginal suspension and vaginal fixation for the correction of retroflexions and retroversions. From that time on, this route found an increasing number of indications until it was used, and can be used today, as a path for the performance of almost any operation included under the phrase, "operation for pelvic gynæcological disease."

The posterior route has been used for years in the opening of pelvic abscesses. This, however, is strictly not a celiotomy, for, in a large proportion of cases, the pus is not in the peritoneal cavity, but is in the pelvic connective tissue posterior or lateral to the uterus. In the vast majority of cases of large pyosalpinges and tubo-ovarian abscesses opened per vaginam, adhesions in the cul-de-sac of Douglas practically wall off the peritoneal cavity. The posterior route is, of course, of value in the treatment of pelvic peritonities according to the method of Pryor.

This posterior path may be used to great advantage in the removal of small movable ovarian tumors which are prolapsed into the cul-de-sac of Douglas. Its main value is as a diagnostic aid, especially in differentiating intrauterine from extrauterine gestation. The operation is extremely simple; it takes only a minute to enter the peritoneal cavity by a longitudinal or preferably transverse incision. If no free blood or clots are found

*Reprinted by special permission from the Post-Graduate, Dec. 1909.