SOME POINTS IN THE OPERATIVE TECHNIQUE OF VAGINAL HYSTERECTOMY FOR PROLAPSUS

By THOMAS S. CULLEN, M.D., Baltimore, Maryland

It is not my intention to discuss here the relative merits of the various abdominal or vaginal operations for prolapsus of the uterus. Marked prolapsus usually demands operative interference. If the patient comes prior to the menopause, the uterus should be preserved if possible, and even in women who have passed the menopause it may sometimes be deemed wiser to save the uterus on account of the probability of a prolapsus of the vaginal vault at a later date. In a certain number of cases, however, there is marked prolapsus of the uterus associated with much redundancy of the anterior and posterior vaginal walls and occasionally with a greater or less amount of ulceration. In this group of cases vaginal hysterectomy combined with a wide removal of the surrounding vaginal mucosa, closure of the vaginal vault and repair of the perineum, as described in the following paragraphs, gives excellent results.

The accompanying case was the first in which we employed this procedure.

Vaginal hysterectomy with wide excision of the vaginal mucosa in a case of extensive prolapsus uteri with ulceration of the cervix and vagina.

Mrs. E. L., aged 72, white, seen in consultation with Drs. Chapman and McCormick of Trappe and Brice Goldsborough of Cambridge, Md., March, 1905. This patient for 52 years has been suffering from prolapsus of the uterus, but never told her physicians about it until a few weeks ago. Until recently she has gotten along without much difficulty.

Accompanying the prolapsus is marked descensus of the bladder. The cervix (Fig. 1) is greatly thickened and there are teat like projections from its surface. A long scar seven or eight cm. in length runs up the right side of the cervix along the vaginal mucosa. The left side is a similar but smaller one covered over with epithelium.

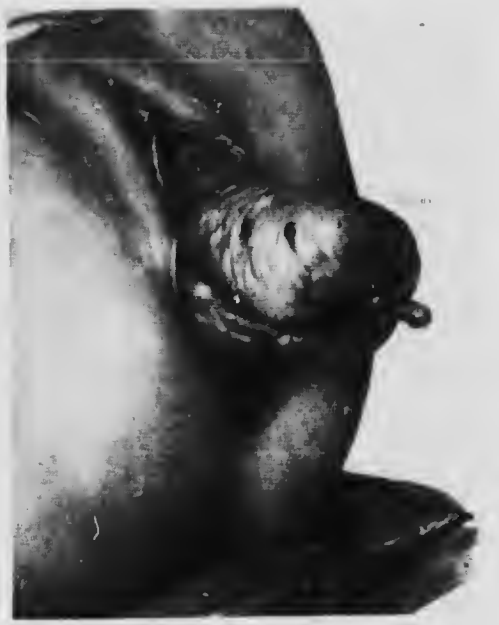

Fig. 1. *Marked prolapsus of the uterus.* The cervix is much enlarged as is evident springing from it is a teat-like projection more than 1 cm. long. On the right side of the cervix and extending far out on to the vagina is an area of ulceration. A similar but smaller one is noted on the left. On the anterior vaginal wall are two small ulcerated areas. The dotted line indicates the outline of the incision. It passes through the vaginal mucosa but no farther. After it has been determined just how much vaginal mucosa should be removed with the cervix, this incision is carried completely around the cervix. In this case all the ulcerated area was naturally included and posteriorly a flap of vaginal mucosa 7 cm. broad was removed with the cervix.

I outlined the area to be removed at the commencement by cutting just through the vaginal mucosa all the way around as indicated by the dotted line. I then dissected the vaginal mucosa downwards from the bladder, entered Douglas' cul-de-sac behind in order that I might get my bearings (Fig. 2), removed the uterus and joined the vaginal mucosa to the peritoneum of Douglas' pouch (Fig. 3). The peritoneum of the anterior pelvic wall was then sutured to that of the posterior wall, and in this way the pelvis was completely shut off (Fig. 4).

Path. No. 8459. The specimen consists of a prolapsed uterus together with a large cuff of vaginal mucosa. The cervix itself is 7 cm. wide, and 5 cm. in its anteroposterior diameter. Surrounding the cervix is a cuff of vaginal mucosa varying from 2 to 7 cm. in breadth.

In such a case as this one finger in the pelvic cavity is of the greatest assistance. After the area to be removed has been outlined and the vaginal mucosa has been carefully dissected downwards in front, care being taken not to enter the bladder, an incision is made behind the cervix and Douglas' pouch is entered. The left index finger