A CLINICAL LECTURE ON ANATOMICAL LESIONS OF THE FEMALE PERINEUM.

Delivered at the Long Island College Hospital,

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GENTLEMEN: I desire to call your attention to the subject of lacerations of the female perineum, and the results which may occur if appropriate treatment be neglected for the restoration of its function.

The various degrees of this laceration are clearly stated in our modern text-books, consisting, as they do, of three degrees, viz.:

1. Superficial rupture of the fourchette and perineum, not involving the sphincters.

2. The rupture extending to the sphincter ani.

3. Rupture through the sphincter ani, which may involve the recto-vaginal septum.

There are some lesions, however, the final results of which have not been discussed in our literature at the present day, and to which I would specially direct your attention, while discussing the subject of perineal lacerations, in those cases who may present themselves at our clinic to-day.

The first to which I shall direct your attention is the separation of the perineal muscles at their junction in the median line, without an accompanying laceration of the vaginal mucous membrane or the integument of the perineum. The appearance of the parts, viewed externally, gives no evidence of the lesion, the distance from the posterior commissure to the anus being perfectly normal. On separating the labia, however, or on introducing the speculum, the posterior vaginal wall also appears to be uninjured, but, upon examination by the touch, the deeper structures of the perineal body are observed to be absent. In passing the finger into the vagina and making pressure backward and downward, the mucous membrane of the lower portion of the vagina can be brought directly in contact with the integument below.

A similar condition of things I have quite frequently observed in patients upon whom the operation of perineorrhaphy had been performed, with the result of obtaining union of the integument and mucous membrane without restoring the perineal body.

In this condition of separation of the deeper structures of the perineum, the effect is precisely the same as in those cases where the mucous membrane and integument have also been lacerated, as they ordinarily are. The sustaining and supporting power of the perineum is entirely lost. The integument and mucous membrane are relaxed, and hence permit eversion of the vaginal walls, and subsequently prolapsus of the uterus and bladder. In one case which I have seen—a lady of over sixty years of age—it appeared that a portion, at least, of the sphincter-ani muscle had been ruptured, at any rate, the patient had very imperfect control of the rectum, and still, on superficial examination, the perineum appeared to be complete, so far as skin and mucous membrane were concerned. I am inclined to think that what has been described by Matthews Duncan and others as functional imperfection of the perineum has really been this subcutaneous laceration of the central structures of the perineum.

Regarding the cause of this condition, I am inclined to believe that it is the same as that in ordinary lacerations—namely, parturition.

I accept this view of the causation because in all the cases I have seen there has been a precedent parturition. In these cases it would seem that the elasticity of the muscular structures was less than that of the integument and mucous membrane, so that, while the former gave way when put upon the stretch, the latter came out uninjured.

Regarding the treatment of this condition, I am not quite satisfied that anything of value can be done for it. If the case is recent and the perineal muscles have not become atrophied, then I believe it would be good practice to divide the integument and mucous membrane, and, if need be, removing the superabundant portions of these latter bring the deeper parts together—if possible, with sutures as in the ordinary operation for restoring the perineum. The second condition is more rare than the one just described, and consists in atrophy of the perineal muscles, including the levator-ani muscle.

A typical case of this affection came under my observation in 1879. She was forty-four years of age, married, and had had several children. She had prolapsus of the vaginal walls, and a slight prolapsus of the uterus. These conditions were quite apparent on superficial examination; but a more careful study of the case revealed the following: The distance from the posterior commissure of the vulva to the anus was normal; but, upon grasping the perineum, with the index finger in the vagina and the thumb upon the outer surface, no intervening muscular tissue could be detected. The posterior vaginal wall could be brought in direct contact with the integument. On the most careful digital examination by the vagina, I failed to detect any evidence of muscular tissue. Running from the centre below to the left sacro-iliac junction, the rectum could be distinctly felt firmly contracted, feeling through the vaginal wall like a cord the thickness of the finger.

This was demonstrated by passing a catheter into the rectum, showing that there was firm contraction of its muscular walls, and yet its dilatability remained normal, as evidenced by the fact that the bowels moved easily and freely. Although there was a marked prolapsus of the posterior vaginal wall there was not the slightest rectocele, when the patient assumed the erect position, the anus and perineum bulged downward; this was also ap-