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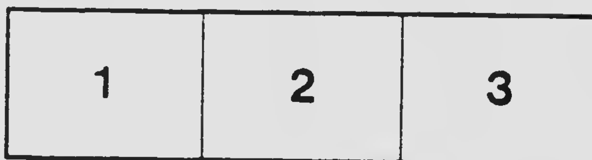

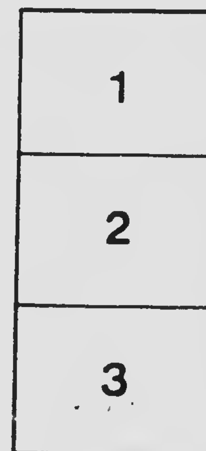

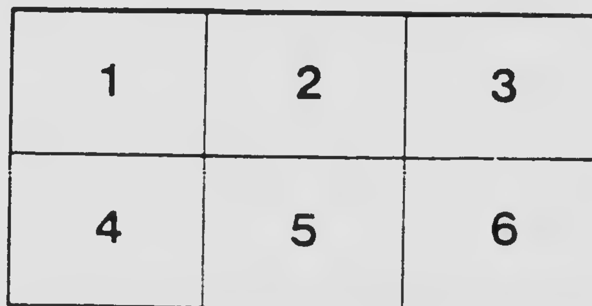

SOME POINTS IN THE OPERATIVE TECHNIQUE OF VAGINAL HYSTERECTOMY FOR PROLAPSUS

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

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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 projec[illegible] surface. A long scar seven or eight cm. i[illegible] up the right side of the cervix along the va[illegible] the left side is a similar but smaller one [illegible] covered over with epithelium.

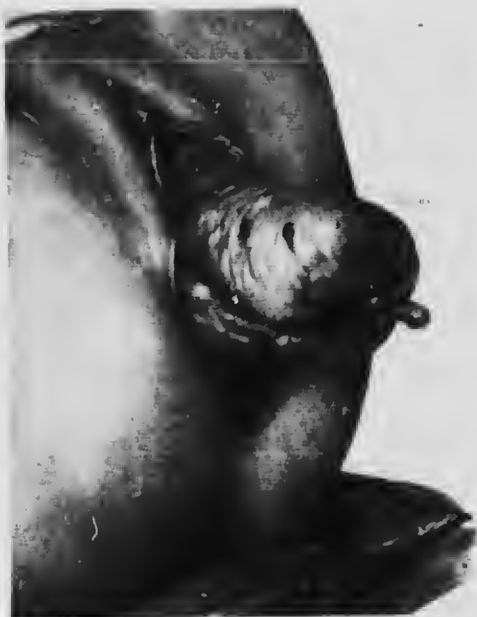

Fig. 1. *Marked prolapsus of the uterus.* The cervix is much enlarged and springing from it is a teat-like projection more than 1 cm. long. On the right side of the cervix and extending far out on to the vagina is an area of ulceration. A similar but smaller one is noted on the left. On the anterior 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

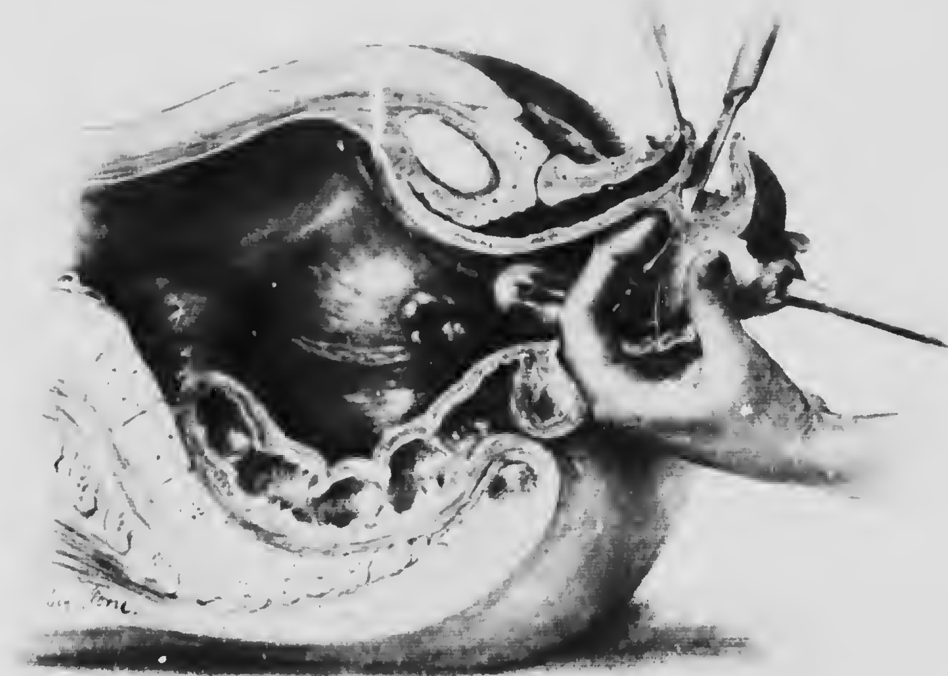

Fig. 2. *The finger as a guide in separating the bladder from the cervix.* The vaginal flap was dissected downwards from the bladder. Douglas' pouch was then opened up along the dotted line, and the left index finger carried down in front of the cervix tended to shove the bladder upward and away from injury while the knife dissected it from the cervix. In this case the tissue between the bladder and cervix was denser than usual.

can be passed through this opening, hooked over and carried down in front of the cervix between it and the bladder. The knife gradually cuts down upon this at a fixed point. By the employment of this method there is much less danger of injuring the bladder (Fig. 2).

After control of all the blood vessels and removal of the uterus with or without the appendages, as is deemed advisable, the peritoneum of the pelvis is drawn down and attached to the vaginal mucosa. In this way the stumps of the vessels are completely covered over and nothing but a small opening persists between the pelvis and the vagina. When one removes a large area of vaginal mucosa, as in this case, and then joins the peritoneum to the vaginal mucosa, the remaining portion of the vagina is drawn up as it were into the pelvis, no slack being left (Fig. 3), and the bladder which has been prolapsed is again carried up into a relatively normal position.

It is comparatively easy to join the peritoneum of the posterior part of the pelvis to that of the anterior part. By means of several sutures introduced at different levels the peritoneal surfaces are approximated over a considerable area and the now shallow vagina is completely cut off from the pelvis. Care must be taken when suturing the peritoneum not to pierce any of the large vessels, otherwise troublesome oozing or a hæmatoma may follow.

We have removed the uterus in this way in several instances with great satisfaction. The method is applicable chiefly to those cases where marked prolapsus exists.

If the tissues are not brought up quite as snugly as one would wish, the perineum may be repaired.

Fig. 3. *Appearance of the lower part of the pelvis after the pelvic peritoneum has been united to the vaginal mucosa.* The pelvic peritoneum has been joined to the vaginal mucosa by means of interrupted catgut sutures and the stumps of the vessels have been covered over. The bladder has been drawn well up and the vagina is much shortened.

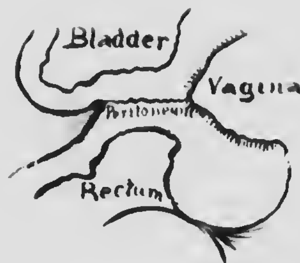

Fig. 4. *Closure of the pelvis.* The pelv. peritoneum is united over an area from 2 to 3 cm. long, care being taken not to pierce any vessels. If the vagina is lax, the perineum should be repaired.

I thought that this operation was original (if any vaginal hysterectomy can really be considered new) until my visit to Rochester a few years ago. There I saw Dr. Wm. J. Mayo do an operation somewhat similar in character, the only differences being that he did not take out so large a cuff of vaginal mucosa surrounding the cervix as we have done, and that Douglas' pouch was not at once opened up and a finger introduced as a guide. These, of course, are only minor differences.